Office of Information Governance and Privacy

U.S. Department of Homeland Security
500 12th St., SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

February 14, 2023

Mehreen Rasheed
American Oversight
1030 15th Street, NW, Suite B255
Washington, DC 20005

RE: ICE FOIA Case Number 2020-ICFO-29037

Dear Mehreen Rasheed:

This letter is the final response to your Freedom of Information Act (FOIA) request to U.S. Immigration and Customs Enforcement (ICE), dated March 20, 2020. You have requested various records pertaining to ICE Health Service Corps Quality Improvement Audits, inspection reports and action plans for several detention and correctional centers. ICE has considered your request under the FOIA, 5 U.S.C. § 552.

A search of the ICE Enforcement and Removal Operations (ERO) for records responsive to your request produced 2966 pages and 3 excel spreadsheets that are responsive to your request. After review of those documents, I have determined that 1,032 pages will be released in their entirety. Portions of 1,934 pages will be withheld pursuant to Exemptions of the FOIA as described below.

ICE has applied Exemption 5 to protect from disclosure intra-agency documents that contain the recommendations, opinions, and conclusions of agency employees. The disclosure of these communications would discourage the expression of candid opinions and inhibit the free and frank exchange of information and opinions among agency personnel on important agency decision-making by having a chilling effect on the agency's deliberative process.

FOIA Exemption 5 protects from disclosure those inter- or intra-agency documents that are normally privileged in the civil discovery context. The three most frequently invoked privileges are the deliberative process privilege, the attorney work-product privilege, and the attorney-client privilege. After carefully reviewing the responsive documents, I have determined that portions of the responsive documents qualify for protection under the deliberative process privilege, the attorney-client privilege, and the attorney work-product privilege. The deliberative process privilege protects the integrity of the deliberative or decision-making processes within the agency by exempting from mandatory disclosure opinions, conclusions, and recommendations

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included within inter-agency or intra-agency memoranda or letters. The release of this internal information would discourage the expression of candid opinions and inhibit the free and frank exchange of information among agency personnel. The attorney work-product privilege protects documents and other memoranda prepared by an attorney in contemplation of litigation. The attorney-client privilege protects confidential communications between an attorney and his client relating to a legal matter for which the client has sought professional advice. It applies to facts divulged by a client to his attorney, and encompasses any opinions given by an attorney to his client based upon, and thus reflecting, those facts, as well as communications between attorneys that reflect client-supplied information. The attorney-client privilege is not limited to the context of litigation.

ICE has applied FOIA Exemptions 6 and 7(C) to protect from disclosure the names, e-mail addresses, and phone numbers of DHS employees contained within the documents.

FOIA Exemption 6 exempts from disclosure personnel or medical files and similar files the release of which would cause a clearly unwarranted invasion of personal privacy. This requires a balancing of the public's right to disclosure against the individual's right to privacy. The privacy interests of the individuals in the records you have requested outweigh any minimal public interest in disclosure of the information. Any private interest you may have in that information does not factor into the aforementioned balancing test.

FOIA Exemption 7(C) protects records or information compiled for law enforcement purposes that could reasonably be expected to constitute an unwarranted invasion of personal privacy. This exemption takes particular note of the strong interests of individuals, whether they are suspects, witnesses, or investigators, in not being unwarrantably associated with alleged criminal activity. That interest extends to persons who are not only the subjects of the investigation, but those who may have their privacy invaded by having their identities and information about them revealed in connection with an investigation. Based upon the traditional recognition of strong privacy interest in law enforcement records, categorical withholding of information that identifies third parties in law enforcement records is ordinarily appropriate. As such, I have determined that the privacy interest in the identities of individuals in the records you have requested clearly outweigh any minimal public interest in disclosure of the information. Please note that any private interest you may have in that information does not factor into this determination.

ICE has applied FOIA Exemption 7(E) to protect from disclosure internal agency case numbers contained within the document.

FOIA Exemption 7(E) protects records compiled for law enforcement purposes, the release of which would disclose techniques and/or procedures for law enforcement investigations or prosecutions or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law. I have determined that disclosure of certain law enforcement sensitive information contained within the responsive records could reasonably be expected to risk circumvention of the law. Additionally, the techniques and procedures at issue are not well known to the public.

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You have a right to appeal the above withholding determination. Should you wish to do so, you must send your appeal and a copy of this letter, within 90 days of the date of this letter following the procedures outlined in the DHS FOIA regulations at 6 C.F.R. Part 5 § 5.8. You may submit your appeal electronically at GILDFOIAAppeals@ice.dhs.gov or via regular mail to:

U.S. Immigration and Customs Enforcement
Office of the Principal Legal Advisor
U.S. Department of Homeland Security
500 12th Street, S.W., Mail Stop 5900
Washington, D.C. 20536-5900

Your envelope and letter should be marked "FOIA Appeal." Copies of the FOIA and DHS regulations are available at www.dhs.gov/foia.

Provisions of FOIA allow DHS to charge for processing fees, up to $25, unless you seek a waiver of fees. In this instance, because the cost is below the $25 minimum, there is no charge.

If you need any further assistance or would like to discuss any aspect of your request, please contact the FOIA office and refer to FOIA case number **2020-ICFO-29037**. You may send an e-mail to ice-foia@ice.dhs.gov, call toll free (866) 633-1182, or you may contact our FOIA Public Liaison, Fernando Pineiro, in the same manner. Additionally, you have a right to right to seek dispute resolution services from the Office of Government Information Services (OGIS) which mediates disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. If you are requesting access to your own records (which is considered a Privacy Act request), you should know that OGIS does not have the authority to handle requests made under the Privacy Act of 1974. You may contact OGIS as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001, e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

Sincerely,

Joshua J. Fahrnkopf
Supervisory Paralegal Specialist

Enclosure: 2966 pages and 3 excel spreadsheets

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Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	5.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	4.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	15.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	15.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	7.00
Number of sick call encounters where the reason is documented in the "Reason" field.	24.00
Number of sick call encounters where the reason for the visit was from an approved category.	24.00
Number of sick call encounters addressed by a nurse.	23.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	23.00
Findings	(b)(5)
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	Yes
Findings	No descrepancies. Sick call was performed efficiently and provided the detainee with education on his condition.
Deliverables	NO DATA

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	0.00
Number of MHU 23 hour observation records with discharge encounters.	0.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	0.00
Number of MHU 23 hour observation records with telephone order admission.	0.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	0.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	NO DATA
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	N/A - See findings below.
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	0.00
Number of MHU full admission records reviewed.	25.00
Number of MHU full admission records with admission encounters.	22.00
Number of MHU full admission records with discharge encounters.	16.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	14.00
Number of MHU full admission records with no PE within the past year.	0.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	0.00
Number of MHU full admission records with acuity level assigned.	23.00
Number of MHU full admission records with all medications placed on pill line.	25.00
Number of MHU full admission records with 24 hour chart reviews everyday.	23.00
Number of MHU full admission records for patients in segregation for medical overflow.	16.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	15.00
Number of MHU full admission records with a nursing care plan.	25.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	24.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	24.00

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Number of MHU full admission records with mental health diagnoses.	14.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	14.00
Number of MHU full admission records without mental health diagnoses.	11.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00
Findings	9- no discharge encounter 2- no 24 hour chart check 2- no acuity level 3- no admission encounter 1- no daily nursing check
Deliverables	NO DATA

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Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	10.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	10.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	10.00
Number of suicide watch records where the need for finger foos was annotated.	10.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	10.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	10.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	10.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	10.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	7.00
Findings	This reviewer only found 10 suicide charts. 3/10 charts did not have the custody form scanned into eCW
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	- There were no patients on suicide watch during the site assessment, they had one detainee on mental health observations. It was discovered one detainee was ordered 30 minute mental health observation which is against IHSC OM 16-002.
Deliverables	(b)(5)

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Hunger Strike - Review Complete

Number of hunger strike records reviewed.	1.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	1.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	1.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	1.00
Number of hunger strike records with special needs.	1.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	1.00
Findings	This reviewer only found one hunger strike chart. The chart did not have consistent tracking of I/O's. I did not find the IHSC Form 839 scanned in to the chart or the electronic version. The following are not negative findings: The chart did not have initial orthostatic vitals signs noted because the detainee refused (refusal form noted in chart). The detainee refused labs (refusal forms noted in chart).
Deliverables	NO DATA

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Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	25.00
Number of segregation records where daily segregation rounds by nursing are documented.	23.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	25.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	25.00
Number of segregation records where the patient was seen weekly by mental health.	25.00
Findings	NO DATA
Deliverables	NO DATA

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	5.00
Number of after hours medication records with the patient's identification number documented.	5.00
Number of after hours medication records with medication order(s) documented in eCW.	5.00
Number of after hours medication records that were generated by a nurse as a telephone order.	4.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	4.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	- 1 chart was ordered by and given by a NP. - Log did nto include detainees first and last names
Deliverables	(b)(5)

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	No Findings - Cabinet was very well organized, meds easy to find. Documentation is clear and easy to follow.
Deliverables	NO DATA

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Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	23.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	23.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	8.00
Reasons for why a translator was not used.	Out of the 25 charts reviewed for language access purposes, 8 documented use of a translato, and provided translator name or number. For the 17 that did not use a translator, they all documented why a translator was not used. Following are the reasons that were provided: 1. provider fluent in detainee's language 2. not applicable/patient speaks English
Findings	Out of the 25 charts reviewed, two (2) did not document that the detainee was asked what language they speak, and/or did not document detainee's primary language/language of choice.
Deliverables	NO DATA

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	NO DATA
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	NO DATA
Findings	"I Speak" 8x10 posters in all patient exam rooms and intake areas. - Facility has sign language process available; however, some staff were not aware of the process; however, they knew to contact AHSA or HSA if the need raised.
Deliverables	NO DATA

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Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	No Findings - Lab is well organized and staff are knowledgeable about the processes and procedures for the lab and radiology.
Deliverables	NO DATA

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Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	3.00
Number of refridgerator temperature logs that are up to date.	3.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	- Pharmacy refrigerator temperature is not recorded on weekends or holidays as no pharmacy staff are working and current thermometer does not record multiple days temperature. - Hemmoult control log was not in use. - U/A Daily controls were not being performed, it was being performed when a new box was opened.
Deliverables	(b)(5)

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Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	3.00
Number of daily assignment sheets completed and archived .	3.00
Number of daily assignment sheets with one emergency team identified per shift.	0.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	3.00
Number of daily assignment sheets with clinic inspection completed and signed.	0.00
Are detainee referrals documented?	Yes
Findings	(b)(5)
Deliverables	(b)(5)

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Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	No - See findings below.
Findings	The adjustments to time are submitted via email by the employee to the HSA/AHSA and approval or denial is sent sent back with cc to the AA. The employee annotates what is approved on their e-timesheet. The printout from the timeclock does not have annotation of approved changes.
Deliverables	(b)(5)

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	0.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	- Has participated in national PHSP meetings but has not had local meetings to disseminate the information to local staff. - QI meetings for 1 and 2nd quarter were reviewed, third quarter meeting has not been held but will be held June 28. - ICE/HSA meeting minutes reviewed for 1st and 2nd quarter and compliance officer indicated the 3rd quarter meeting was held in April and attended by former HSA; however, they were unable to locate records during the site assessment. Oct and March were reviewed
Deliverables	(b)(5)

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Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	2.00
Number of federal civil service employee personnel files reviewed.	0.00
Number of contractor personnel files reviewed.	8.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	Yes
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	3.00
Of the personnel file records for priveleged staff, how many are current?	3.00
Number of personnel files with current and signed Health and Ability form.	10.00
Number of personnel files with a signed statement of confidentiality (one time).	10.00
Number of personnel files with a signed statement of risks and responsibility (one time).	10.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	10.00
Number of personnel files with a signed release of information form (one time).	10.00
Findings	- Dates were annotated with a line versus actual dates
Deliverables	(b)(5)

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Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	2.00
Number of federal civil service employee credentialing files reviewed.	0.00
Number of contractor credentialing files reviewed.	8.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	10.00
Number of credentialing files with current, valid, and unrestricted license.	9.00
Number of credentialing files with license primary source verification.	9.00
Number of credentialing files with documentation of primary education.	9.00
Number of credentialing files with education primary source verification.	0.00
Number of credentialing files reviewed for physicians or psychiatrists.	1.00
Number of physician or psychiatrist credentialing files with documentation of residency.	0.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	1.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	1.00
Number of credentialing files with a curriculum vitae or resume.	10.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	2.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	3.00
Number of credentialing files with scope of practice.	8.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	0.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	8.00
Number of peer reviews reviewed.	1.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	1.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	- 1 file was MRT (no license required) - Only 1 CV had any indication of being revised within last year. - Only 3 files required NPD - Only 8 files required Scope of Practice - 1 MD was missing current peer review - Electronic Tracker system is identified as Best Practice.
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	5.00
Number of employee health files with current TB (PPD or CXR) documentation.	5.00
Number of employee health files with current Hepatitis B vaccination or declination form.	5.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	4.00
Number of employee health files with current respirator medical clearance.	5.00
Number of employee health files with current respirator fit test.	5.00
Number of employee health files with emergency contacts.	5.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	N/A - See findings below.
Findings	-Emergency Contact info is maintained in the Personnel File. Reccomend form add a date, so it is clear that the information is current.
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	10.00
Number of training folders with HSD-500.	10.00
Number of training folders with a signed position description.	10.00
Number of registered nurse training folders reviewed.	5.00
Number of registered nurse training folders with RN Physical Exam Training.	5.00
Number of training folders with continuing medical education credits.	7.00
Number of training folders with BLS for health care providers or CPR and AED certification.	10.00
Number of radiation safetoy officer training folders with radiation safety training.	1.00
Findings	No Findings - All files are organized and well maintained. Electronic tracker that covers credentialing, training, Employee Health as well as other employee items that are tracked is identified as a Best Practice.
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	No - See findings below.
Findings	- No routine monitoring of hand hygiene was being conducted.
Deliverables	(b)(5)

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Schedules - Review Complete

Number of schedules reviewed.	8.00
Number of schedules with a legend to explain codes.	8.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	8.00
Number of schedules with evenly distributed staffing throughout the week.	8.00
Number of schedules with provider coverage on weekend/holidays.	8.00
Number of schedules with actual work hours reflected for non-traditional shifts.	8.00
Are there signed approvals for non-traditional shifts?	No - See findings below.
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	-Per RHSA: No current approval for non-traditional shifts: Awaiting new compressed work schedule OM to initiate.
Deliverables	(b)(5)

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IHSC Health Systems Assessment

Facility Overview

Months: May - July 2018 **Bed Capacity:** 1500 **MHU Beds** 0
Daily Census: 1428 **Male:** 1003 **Female:** 425 **Juveniles:** N/A **LOS:** 57

Average Number of Encounters

Category	Month 1	Month 2	Month 3	Average	% pop
Pre-screening	1,052	1,022	888	987	
Intake	1,050	1,013	888	984	
Physical Exams	744	776	669	730	
Vitals/Labs	357 / 186	238 / 200	327 / 411	307 / 266	
Sick call	1,115	1,075	936	1,042	
Pros/Imm	459 / 7	484 / 1	409 / 12	451 / 7	
Acute	281	275	1,192	583	
Chronic	212	208	188	203	
Mental Health	404	419	456	426	
Dental	109	119	117	115	
Emergent/Urgent	15 / 204	24 / 250	31 / 282	23 / 245	
MHU	289	448	652	463	
Seg	574	510	556	547	
Admin	81	88	178	116	
Transfers	928	907	1,020	952	
Totals	8,067	8,057	9,212	8,445	
Pill-line passes	21,824	21,213	21,789	21,609	
RX (Pill-line + KOP)	2,921	2,594	2,497	2,671	
Referrals / ER	122	112	99	111	

Staffing

	PHS	GS	CTR	Vacant	Total
AA/MRT	(b)(7)(E)				
CD/MD					
DA/DT					
DDS					
HSA/AHSA					
LVN/LPN					
MA/CNA					
MHP					
MLP					
MRT					
PharmD					
PharmTech					
PsychMD					
RDH					
RN					
X-ray tech					
Totals					

Comments:

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PRE-ARRIVAL REVIEW

Accreditation

Most recent ACA, NCCHC, and PBNDS surveys. List type of survey and date.

Evaluation Method		
Survey	**Date**	**Findings / Recommendations**
ACA	3/12/18	100% Compliant
NCCHC	5/31/18	38 of 39 Essential standards compliant (J-C-01 Credentials) Corrected onsite 25 of 26 Important standards compliant (J-F-02 Medical Diets) Corrected
PBNDS	2/05/18	100% Compliant

Comments

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Grievances

Evaluation Method:	Observation	
Items to Review *(review 100% during past year)*	**Yes, No, or N/A**	**Comments**
1. Have there been any medical grievances reported through QI/JIC/CRCL/DRIL *(if so, provide type in comment section)*	Yes	CRCL - all addressed in timely manner
2. Is there a local procedure (SOP) for managing grievances?	Yes	LOP 302 Medical Grievance Mechanisms
3. Is there an identified grievance officer?	Yes	CDR Spady-Grove
4. Is the log book kept and up to date?	Yes	
5. Were all Grievances addressed in a timely manner?	Yes	
6. Number of Formal/Informal grievances: 18 / 0		

Findings/ Recommendations:	. No trends noted
Deliverables:	**N/A**

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Facility:	Reviewers:	Dates:

Incident Reports /RCA/SOE

Evaluation Method:			
Items to Review *(review 100% during past year)*		**Yes, No, or N/A**	**Comments**
1. Were there any trends noted from reported incident reports or RCAs for FY17?		No	
2. Are there any active RCAs/SOE?		Yes	
3. Has a RCA or SOE been completed during this FY? If so, complete #4		Yes	
4. Was a CAP initiated and/or completed for the RCA or SOE?		Yes	1 CAP R/T loss of limb
a. If CAP initiated, note status and due date.		6 month f/u 2/28/19	
Findings/ Recommendations:	None		
Deliverables:			

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ON-SITE OBSERVATIONS

During site observations, the reviewers should observe staff members carrying out the task, interview staff, review medical records and review supporting documents (i.e. logs, minutes, binders, electronic trackers, etc.).

Medication Administration (Observations-Onsite Review)

Question (10 ENCOUNTERS)	Improvement Plan(1,2, or3)	Comments
Is pre-pouring occurring? **(Be sure to observe more than one nurse on multiple shifts) Level 2@100%**		No 10/10
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)? **Level 2 @100%**		Yes 10/10
Are mouth checks being conducted with every administration? Observe 10patients(if possible) on multiple shifts **Level 1 @80%**		Yes 10/10
Are all entries in the MAR complete (allergies, staff initials, etc.)? Observe 10 different MAR; **Level 1 @80%**		Yes 10/10
Are nurses documenting the medication administration immediately after The medication is administered**? Level 2 @100%**		Yes 10/10
Number of all medication refusals documented on the MAR/eMAR **Denominator**		8

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Of the identified medication refusals from the MAR, how many refusals did have an accompanying signed refusal form? **Level 2@90%** .		8 of 8 100%
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal in eCW **Level 1 @100%; See guide on ECW notification**		None

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Emergency Preparedness and Response

Question	Improvement Plan(1,2, or3)	Comments
Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)? Refer to guide: **level1@90%** Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)? Refer to guide **level 1 @90%** Is there documentation showing completed date and time of mass casualty drills * (each shift should have a complete drill with in a three year period)? *Table top/mock drills are acceptable replacements for drills not conducted facility wide Refer to guide: **level 1 @90%** Are clinic staff trained on emergency equipment (AED, first Aid kits, fire extinguisher, etc?) Yes/No **level1@90%**		YES 100% Yes Yes Yes Yes
Do emergency scenarios vary? Yes/No?? **Level100%ifNo**		YES 100% Yes
Is the difference between a drill and an actual event evident in the write-up?): **Level 1 @100%**		YES 100% Yes
Is there process in place to distribute "an after-action report to all staff**?** **Level 1 @90%:**		YES 100% Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event? **Level 1 @100%**		YES 100% Yes
Comments:	None	
Deliverables:	None	

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Consent Forms

	Section Completed Under the Pre-Audit Chart Reviews		
Question		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of consent forms(General consent) that were complete (not missing detainee signature, witness, or date). **Level1 @100%:** Can escalate to Level 2 if not resolved by the completion of the assessment			100%
2. Number of dental consent forms among the identified consent forms.			12
3. Number of dental consent forms that were complete (missing detainee signature, witness, or date) **Level 1 @90%**			100%
4. Number of psychotropic consent forms among the identified consent forms.			4
5. Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date) **(Level 1 @90%)**			100%
Findings/ Recommendations:	None		
Deliverables:	None		

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Transfers

Reviewer

Evaluation Method:	**Section Completed Under the Pre-Audit Chart Reviews**	
Items to Review *(review25records inthepastmonth)*	**Improvement Plan Levels (1,2,or 3)**	**Comments**
1. Number of outgoing transfers authenticated appropriately (signed, stamped,anddated): **Level1@100%**		100%
2. Number of outgoing transfers completedbyLVNorabove. **Level 1 @100%,**		100%
3. Numberofnoteswith TB clearance noted (PPD, CXR, current CXR from other facility) Level 2 @90%		100%
4. Of the 25 transfers reviewed for TB clearance documentation, how many correctly documented no TB treatment status? **see guide Level 2@90%**		100%
5. Of the 25 transfers reviewed for TB clearancedocumentation,howmany- incorrectly documented no TB treatment status? see guide **Level 2@90%**		100%
6. Of the 25 transfers reviewed for TB clearancedocumentation,howmany- correctlydocumentedTBtreatment status? see guide: **Level 2@90%**		100%
7. Of the 25 transfers reviewed for TB clearancedocumentation,howmany- incorrectly documented TB treatment status? see guide: **Level 2@90%**		100%

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Facility:	Reviewers:	Dates:

Findings/ Recommendations:	None
Deliverables:	None

Pre-Screening

Reviewer:

Evaluation Method:	**Observe 10 pre-screens if Possible**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of prescreen encounters observed. **Denominator**		10
2. Are language services being used during pre-screen if appropriate? **Level2: if No**		Yes
3. Number of prescreens with documentation completed in eCW prior to intake screening. **Denominator**		10
4. Number of prescreen encounters prioritized. **Level1: @90%**		6
5. Number of Pre-screens encounters not prioritized appropriately: **Level 1 @90%**		None
Findings/ Recommendations:	None	

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Intake Screening

Evaluation Method:	Observe 10 "Intakes" if Possible		
Items to Review *(review25records in the past month)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Numberofintakescreeningsobserved.(N/A) **Denominator**			25
2. Numberofintakescreeningobservationswhere thenursereviewedtheprescreenandtransfer paperworkpriortoinitiatingtheintakescreening. **Level 1 @90%**			25
3. Numberofintakescreeningobservationswherea fullsetofvitalsigns(BloodPressure,Respirations, Pulse,Temperature,weight,PainRatingand(if appropriate) O2Satweretaken.**Level2:@90%**			25
4. Numberofintakescreeningobservationsthat usedlanguage services. **Level 2:@90%**			25
5. Of theintakescreenings that used theeCW IntakeScreeningtemplate,howmanywere completedappropriately(i.e.,defaultanswers changedtoreflectthepatient'sresponse)? **Level 1 @90%**			25
6. Oftheintakescreeningobservationsthatused languageservices,howmanywereappropriately conducted? **Level2:@90%**			100%
7. Number of intake screening observations where thepatientwaseducatedonaccesstocare, upcomingPEappointment,andprovidedthe grievance guide. **Level 2:@90%**			100%

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8. Number of intakescreening observationswith securityadviceofspecialneedsandhousing disposition. **Level 1 @90%**		100%
	None	
Deliverables:		

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Chronic Care

Evaluation Method:	Observe 10 "Chronic Care Encounters"		
Questions		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of chroniccareencountersobservedthat utilized language services appropriately. **Level 2 @90%**			10 / 100%
2. Numberofchroniccareencountersobservedthat were completed within thetimeframe indicated byapreviousvisit (90daysforstableintake screening or stable prior chronic care visit **Level 2 @90%**			100%
3. Numberofchroniccareencountersobservedthat were not completed within the timeframe indicated by a previous visit (greater than 90 days for unstable patients). **Level 2 @90%**			0
Findings/ Recommendations:	None		
Deliverables:			

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Physical Exams

Evaluation Method:	Observe 10 physical exams completed by different providers	
Items to Review *(review25records inthepastmonth)*	**Improvement Plan Levels (1,2,or 3)**	**Comments**
1. Number of physicalexamination encounters with afull set ofvital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken **Level 2@90%**		10 / 100%
2. Number of physicalexamination encounters observed that were completed within the specified timeframe. (Two Business days for PE-Cs, 7daysfor–juvenilesand, 14-days for adults) **Level 2@90%**		100%
3. Number of physicalexamination encounters observed that offered detainee provider referral when appropriate **Level 1 @90%**		100%
Findings/ Recommendations:	None	
Deliverables:		

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Facility:	Reviewers:	Dates:

Sick Call

Evaluation Method:	Observation		
Items to Review *(Observe 10 "Sick Call "Encounters if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Is sick call offered face-to-face on a daily basis?? **Level 1 if NO**			Yes
2. Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented) **Level 1; if NO**			Yes
3. Is translator services offered when appropriate during a sick call process? **Level 1; if NO**			Yes
4. Did RN utilize nursing protocols/guidelines during sick call encounters?			Yes
5. Is a guardian present for any minor (<18 years of age) sick call? **Level 1; if NO and applicable**			N/A
6. Is there a sick call log used to document all encounters?			No

Findings/ Recommendations:	None
Deliverables:	

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Medical Housing Unit 23 hr Observation

Evaluation		
Items to Review *(Observe 10 MHU 23-HR OBS if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU 23 hour observation records reviewed. **Denominator**		
2. Number of MHU 23 hour observation records with documentation regarding Return to general population		
3. Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis documented on placement in the medical housing unit		
4. Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 2 business day. **Level 1: @80%**		
Findings/ Recommendations:	**NONE**	
Deliverables:		

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Medical Housing Unit full Admission Observation

Evaluation Method:	Observation		
Items to Review *(10 detainees if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are all patients within sight or hearing of a qualified health professional? **Yes/No**??			10/10 YES
2. Number of nurses in the MHU at time of observation **(Denominator)**			(b)(7)(E)
3. Number of patients in the MHU at time of observation			
4. Number of MHU full admission records with 24 hour chart reviews every day. (Review one 24-hour chart in detail to confirm review was done appropriately) **Level 1: @90%**			100%
5. Number of MHU full admission records with all medications (except KOP med exceptions see guide) placed on pill line. **Level 2 @90%**			100%
Findings/ Recommendations:		NONE	
Deliverables:			

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Suicide Watch-Observations

Evaluation Method:	None observed on Site		
Items to Review *(Observe 10 detainees on "suicide watch" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of patients on suicide watch **Denominator**			6
2. Number of patients on suicide watch with nursing assessment performed within the past 8 hours. **Level 3 @ 100%**			100%
3. Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule. **Level 3@ 100%.**			100%
4. Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours. **Level3 @ 100%.**			100%
5. Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc). **Level 3@ 100%**			100%
Findings/ Recommendations:	NONE		
Deliverables:			

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Hunger Strike-Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees on "Hunger Strike" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Was water available to detainees on hunger strike? **Level 3: if NO @90%**			100%
2. Were meals (if observed during meal times) offered to patient and how MUCH OF THE of the food SERVED was eaten **Level 3: If NO @90%**			100% of meals were offered to patient, 0% were consumed during hunger strike
3. Of the hunger strike records with special needs, how many records indicate that the needs were addressed? **Level 3 @90%**			N/A
Findings/ Recommendations:	NONE		
Deliverables:	None		

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Facility:	Reviewers:	Dates:

Segregation- Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees in "Segregation" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU full admission records for patients in segregation for medical overflow. **(Denominator)**			N/A
2. Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on every8hours accordingtoMHUpolicy **Level 3 @90%**			N/A
3. Was sick call offered to detainees in segregation or other specialty housing units? **Level 2 @90%**			100%
Findings/ Recommendations:	NONE		
Deliverables:	None		

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After-HoursMedication(nightpharmacy)

Reviewer:

Evaluation Method:	Observation		
Items to Review		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of after-hoursmedication log records reviewed. **(Denominator)**			10
2. Number of after-hoursmedication LOG records that were generated by a nurse as a telephone order. **Level 2 @90%**			4 the remaining 6 after hours medication provider was on sight, however pharmacy was closed
3. Number of afterhours medication records that were generated by a nurse as a telephone order and were signedbyaprovider within24hours returning for next work shift **Level 2 @90%**			4
4. Does the pharmacyhavea reconciliationprocess?: **Level2 if NO @90%**			YES 100%
5. Is an After-Hours Cabinet (AHC) medicationsignout log in placefor the documentation of medications removed from the AHC: **Level 1 @100%**			YES 100%
6. Isall necessaryinformationentered the fields of the After-Hours Cabinet (AHC) sign out log. **Level 1 @100%**			YES 100%
7. Is amedication log in place and reflective of quantities of medication			YES

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storedinthenightcabinet? **(Level 1 if NO)**		
8. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?**Level2@100%:ifNO**		Reflects all with the exception of time
9. Istheafter-hours verbal medication order enteredeCW bythe prescriber uponreturntoduty? **Level 2@100%**		YES 100%
10. Is the after-hours medication administration properly documented on the MAR or inthe electronic healthrecord?**Level 2@100%**		YES 100%
11. Isthe night cabinet, clean, stocked, and organized?		YES
12. Isthe After-Hours Cabinetphysically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications? **Level 2@100%**		YES 100%
Findings/ Recommendations	None	
Deliverables:	None	

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Language Access- Observations

Reviewer:

Evaluation Method:	**Observation**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Arethe "I Speak" posters and pocket guidesreadilyavailableandpostedin theclinic?		YES
2. Doesthefacilityhave aprocess in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities? **If No; level 2; @100%**		YES
Findings/ Recommendations:	None	
Deliverables:	None	

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Diagnostic Services

Evaluation Method:	Observation		
Items to Review		**Improvement Plan Levels (1,2,or 3)**	**Comments**
1. Arelaboratoryservicesprovided in adherence with CLIA Waived testing? **Level 3: @90%**			YES, 100%
2. Is there a current certificate for CLIA-waived testing? **Level 2@100%: CLIA services stopped until obtained.**			YES, 100%
3. Are radiation signs posted on all doors leading to areas with radiation producing equipment? **Level 1 @100%, "SPOT-FIX, may escalateto Tier2 If multiple rooms noted not addressed by the end of the visit**			YES, 100%
4. Are Dosimetry reports reviewed quarterly (MONTHLY FOR DECLARED PREGNACIES) by the Compliance officer or HSA? (Yes/No):**If Nolevel2@100%**			YES, 100%
5. Arestaff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment? **Level 2@100%**			YES, 100%

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6. Are staff dosimeter badges and controls stored in a central location and not near a radioactive source? **Level 2 @ 100%**		YES, 100%
Findings/ Recommendations:	NONE	
Deliverables:	None	

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Log Books

Reviewer:

Evaluation Method:	Observation		
Items to Review		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of pharmacyrefrigerator temperature logs reviewed **(Denominator)**			20
2. Number of pharmacy refrigerator temperature logs that have entries per shift for the past three months. **Level 1 @90%**			20
3. Number of refrigerator temperature logs that are out of range. **(Denominator)**			0
4.Oftherefrigeratortemperaturelogs that are out of range, how many logs have documentation of action taken and follow-up ?(**Level 1 @90%)**			N/A
Are the sharps secured and count accurate? **Level 2 @100%, if NO**			YES, 100%
In review of the past 3 months of sharps counts, are two signatures present for each shift changes ?(**Level 1 @90%)**			YES, 100%
Are the narcotics secured, (double locked) andcountswithinthelast 3 months accurate (clinic and pharmacy supply)? **Level 3 @90%**			YES, 100%
In review of 3 months of controlled substancelogs, aretwo signatures present for each shift change on the narcotics counts? **Level 1 @90%**			YES, 100%

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Aretheurgentcarecart/traumabagand AEDS checked dailyfor content (signatures, AEDfunctionality,and expirationforthepast3months? **Level 2 @90%**		100%
Findings/ Recommendations:	None	

Daily Assignment Sheet(DAS)

Evaluation Method:	Observation	
Items to Review *(review10random days)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Numberof dailyassignmentsheets reviewed per month) **Denominator**		10
2. Number of daily assignment sheets that were archived appropriately.		10
3. Number of daily assignment sheets reviewed had at least one emergency team identified per shift. **Level 1 @90%**		100%
Findings/ Recommendations:	None	
Deliverables:	None	

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Shift Report and Time-cards

Reviewer:

Evaluation Method:	Observation		
Items to Review *(audit 10 random cards)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are shift reports conducted?		*Yes*	*No IP level: best practice*
2. Is there at least one representative from eachdepartment?		*Yes*	*No IP level: best practice*
3. Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?		*Yes*	*No IP level Observation only for 2018 audits*
Findings/ Recommendations:	None		
Deliverables:	None		

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Meetings

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the two previous staff meetings, how many were conducted monthly and properly documented? **Level1@80%**			Both
2. Out of the two previous public health, safety, and preparedness meetings, how many were properly documented? (**Level1 @80%)**			Both
3. Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented? **(Level1 @80%)**			Both
4. Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented. **Level 1 @80%**			Both
Findings/ Recommendations:	**None**		
Deliverables:	None		

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PERSONNEL

Personnel and Credentialing Files

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 12 files each if available*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the 12 personnel and credentialing files reviewed how many were PHS officers **No IP level**			3
2. Of the 12 personnel and credentialing files reviewed how many were federal civil service employee **No IP level**			None
3. Of the 12 personnel and credentialing files reviewed how many were contractors			9
4. Does the facility have a process for tracking requirements electronically?: **No IP level**			Yes
5. Of the 12 personnel and credentialing files reviewed how many records are for privileged staff (physician, psychiatrist, psychologist, dentist, and social worker)?: **No IP level**			5
6. Of the 12 Privileged staff that are Licensed Independent Practitioners (LIPs) how many had current personnel files records current? (Yes/No) **Level 2@100%**			All
7. Of the 12 personnel files reviewed, how many contained a current and signed Health and Ability form? **Level 1 @90%**			All

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8. Of the 12 personnel files reviewed, how many contained a signed statement of confidentiality (one –time statement signed by		All

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staff) **Level 1; @90%**		
9.Ofthe12 personnel files reviewed,how many contained a signed statement of risks and responsibility (one time)?		All
10. Of the12 personnel files reviewed,how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time). **Level 1; @90%**		All
11. Ofthe12personnelfilesreviewedhow many contained a signed release of information form (one time). **Level 1; @90%**		All
13.Ofthe12 credentialing files reviewed, how many contained current, valid, and unrestricted license **Level 3: if not 100%**		All
14. Of the 12 credentialing files reviewed, how many contained documentation of primary education, license primary source, and annual verification **Level1@90%**		All
15. Ofthe12 credentialing files reviewed how many were reviewed for physicians or psychiatrists.		None
16. Of the12 credentialing files reviewed for physician or psychiatrist how many had Documentation of residency.**Level 2@90%**		N/A
17. Of the12 credentialing files reviewed how many board certified physician or psychiatrist had documentation of board certification. **Level 2 @90%**		N/A
18. Of the12 credentialing files reviewed how many had a copy of a curriculum vitae or a		All

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resume. **Level1@90%**		
15. Ofthe12credentialingfilesreviewedhow		

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many PHS officers had at least two years of evaluations (COERS). **Level 1 @90%**		3
19. Of the 12 credentialing files reviewed how many had current National Provider Data Bank information. (renewable every 2 years) **NoIPlevel**		All
20. Of the12 credentialing files reviewed how many had scope of practice documentation (Pertinent staff only)**Level 1@90%**		All
21. Ofthe12credentialingfilesreviewedfor LIPs how many had a competency assessment or peer review. **Level 2 @90%**		All
22. Of the12 personnel files reviewed,how many contained training folders with HSD-500 record. **No IP level**		All
23. Ofthe12personnelfilesreviewed,how many contained training folders with a signed position description. **No IP level**		*No IP level Observation only for 2018 audits* All
24. Ofthe12personnelfilesreviewed,how many contained registered nurse training folders reviewed. **No IPlevel**		*No IP level Observation only for 2018 audits* 5
25. Of the RN personnel files reviewed, how many contained registered nurse training folders with RN Physical Exam Training. **No IP level**		All
26. Ofthe12personnelfilesreviewed,how many contained continuing medical education credits. **No IP level**		All
27. Ofthe12personnelfilesreviewed,how many contained BLS for health care providers or CPR and AED certification. **Level1@90%**		All

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Employee Health Files

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 12 files)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are employee health files kept separate from other files?(Yes/ No)**No IPlevel**			Yes
2. Is access to employee records limited to the compliance officer, HSA, and AHSA(s) and AA? **NoIPlevel**			Yes
3. Of the twelve-employeehealth reviewed how many files had past year's TB(PPD or CXR) documentation. **No IP level**			All
4. Of the twelve-employee health reviewed how many files had Hepatitis B vaccination or declination form. **No IP level**			*No IP level Observation only for 2018 audits* All
5. Of the twelve-employee health reviewed how many files had yearly Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing). **Level 1 @80%**			All
6.Of the twelve employee health reviewed how many files had yearly respirator medical clearance**. Level 1 @80%**			All
7.Ofthetwelveemployeehealthreviewedhow manyfiles hadyearlyrespiratorfittest. **Level1 @80%**			All
8. Of the twelve employee health reviewed how many files had with emergency contacts.			All
9. Are staff injuries and illnesses documented on the Workforce Injury Tool? **Level 2 @90%**			All

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Facility:	Reviewers:	Dates:

Findings/ Recommendations:	None
Deliverables:	None

Training

Reviewer:

Evaluation Method:	Observation		
ItemstoReview *(Review 12 Files)* ***NoIP level****		**Improvement Plan Levels (1,2,or3)**	**Comments**
1. Of the twelve training folders reviewed how many had documentation of completed Mandatory ICE Trainings (seeguide for list oftrainings)			All
2. Of the twelve training folders reviewed how many had documentation of completed IHSC Mandatory Trainings(seeguide for listof trainings)			All
3. Ofthetwelve training folders reviewed how many had documentation of CompletedEmergency preparedness Trainings(see guide for list of trainings)			All
4. Ofthetwelve training folders reviewed how many had documentationof completed Occupational Health Trainings (seeguide for listoftrainings)			All

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5. Of the twelve training folders reviewed howmanyhad documentationof completed TB Management Trainings		All
6. Of the twelve training folders reviewed howmanyhad documentationof completed Mental Health Training for BehavioralHealth Providers(seeguide for list of trainings)		All
Findings/ Recommendations:	None	
Deliverables:	None	

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DHS-ICE-20-0618-A-000059

Schedules

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 3 months Schedules)* *****NoIPlevels*****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the three month schedules reviewed, how many had a legend to explain codes.			All
2. Out of the three month schedules reviewed, how many had staff assigned 40 HRS PER WEEK20" per scheduling period.(Refer to guide)			All
3. Out of the three month schedules reviewed, how many had provider coverage on weekend/holidays.			All
4. Out of the three month schedules reviewed, how many had actual work hours reflected for non-traditional shifts.			All
5. Out of the three month schedules reviewed, how many had signed approvals for non-traditional shifts?			All
6. Out of the three month schedules reviewed, how many had a PDF copy each time a change was made to the schedule?			All
Findings/ Recommendations:	None		
Deliverables:	None		

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DHS-ICE-20-0618-A-000060

Facility:	Reviewers:	Dates:

Summary

Topic	Recommendation

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DHS-ICE-20-0618-A-000061

Facility:	**Reviewers**:	Dates:

Recommendations from Facility

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DHS-ICE-20-0618-A-000062

Facility:	Reviewers:	Dates:

Additional Comments *(include Section and item number)*

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DHS-ICE-20-0618-A-000063

Facility: **Reviewers**: Dates:

Deliverables

Topic	Items	Due	Lead

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DHS-ICE-20-0618-A-000064

Unit Chiefs and Leadership Review Comment & Feedback

Leadership	Recommendations/ Comments/ Fe ed b ac k
Chief of Health Operations	
Chief Advance Practice Practitioner	
Chief of PHSP	
Chief of Nursing Services Unit	
Chief of Medical Quality Management	
DAD-Administration	
DAD-Health Systems Support	
DAD Healthcare Compliance	
DAD Clinical Services Review	
Chief Medical Officer Review	
Chief of Staff Review	
AD, IHSC Review	

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Chief of Health Operations _____

Signature

Chief Advance Practice Practitioner _____

Signature

Chief of Public Health Safety and Preparedness Unit _____

Signature

Chief of Nursing Services Unit _____

Signature

Chief Medical Quality Management Unit _____

Signature

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DHS-ICE-20-0618-A-000066

Leadership Signatures

DAD Health Systems Support _____

Signature

DAD Healthcare Compliance _____

Signature

DAD Administration _____

Signature

DAD Clinical Services Review _____

Signature

Chief Medical Officer Review _____

Signature

Chief of Staff Review _____

Signature

AD, IHSC Review Status _____

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DHS-ICE-20-0618-A-000067

IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
Report generated: undefined
Report generated: undefined

Assessment Information - Leadership Review

Facility	Eloy
Site visit start date	2019-06-24
Site visit end date	2019-06-28
Fiscal Year	FY2019
Fiscal Quarter	Q3
Post-audit corrective action identified	Yes
Immediate corrective action identified	Immediate Corrective Action Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Pending Report Completion
Chief, Medical Quality Management Unit Review Status	Pending Report Completion
DAD, Administration Review Status	Pending Report Completion
DAD, Clinical Services Review Status	Pending Report Completion
DAD, Health Care Compliance Review Status	Pending Report Completion
DAD, Health Systems Support Review Status	Pending Report Completion
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Pending Report Completion

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Facility Information - Review Pending

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	(b)(6); (b)(7)(C)
Bed Capacity	1550
MHU Beds	2
Daily Adult Male Population	537
Daily Adult Female Population	1035
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	No data reported
Facility Information Comments	No data reported

Average Number of Encounters (Past 3 Months)

Prescreenings	700
Intake Screenings	759
Physical Examinations	661
Vitals/Labs	238
Sick Call	882
Pros/Imm	210
Acute	287
Chronic	199
Mental Health	387
Dental	133
Emergent/Urgent	198
MHU	271
Segregation	436
Admin	65
Transfers	594
Pill-Line Passes	No data reported
Prescriptions (Pill-line + KOP)	No data reported
Referrals/ER	No data reported

Accreditation - Review Complete

Last ACA Accreditation	2018-03-12T04:00:00Z

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Last ACA Findings	No data reported
Last NCCHC Accreditation	2018-05-31T04:00:00Z
Last NCCHC Findings	No data reported
Last PBNDS Accreditation	2019-02-05T05:00:00Z
Last PBNDS Findings	No data reported
Accreditation Comments	No data reported

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	6
Of the after hours med log records reviewed, how many records documented the patient's identification number?	6
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	1
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	1
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	5 out of the 6 meds reviewed had an order in the system by the provider. Thus, a telephone encounter was not needed. One of the 6 orders was not documented in the chart via TE to the provider.
After Hours Medication Chart Review Deliverables	Recommendation (b)(5) (b)(5)

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	No
Is the night cabinet, clean, stocked, and organized?	Yes
	Yes

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Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	
After Hours Medication Encounters Findings	Log does not reflect the time that the medication was removed, but it has all other qualifiers (date, name, A#, med, and quanity removed). Medication is not noted in eCW via a telephone encounter. Site is currently using sMARt. Reeconsiliation is performed weekly by pharmacy, but not annotated on log. One of nine entries was not initiated by the nurse and created a missed dose.
After Hours Medication Encounters Deliverables	1. Update log to include the time that the medication was removed. Provide updated log to RHSA by 10/01/2019. (b)(5) (b)(5)

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	24
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	24
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	14
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	13
Of the chronic care records reviewed, how many detainees had psychiatric medications?	3
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	3
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	0
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	3
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	3
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	16
	16

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Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	11
Chronic Care Records Findings	1 of the 25 detainees did not have a PE within 2 days of arrival to facility. 1 of the 25 did not have an updated problem list. 14 of the 25 arrived on medications. 13 of the 14 continued medications as clinically indicated. 11 detainees were not on medications prior to coming to facility. 3 of the 25 were not on medications prior to coming to facility. 3 of the 25 were seen by a MD or APP every 30 days for medication review. This did not apply to the other 22. Of the 25 records reviewed none of the detainees required a visit with a psychiatrist or MD for chronic care management of psychatric medications. Most were not at facility for the full 90 days. 3 out of 25 detainees were seen within 90 days for chronic care management. 16 of the 25 detainees were seen more frequently than 90 days. 11 of the 25 detainees had a global alert set and 14 did not.
Chronic Care Records Deliverables	(b)(5)

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	7
Of chronic care encounters observed, how many were considered stable patients?	6
Of the stable patients observed, how many were completed within the appropriate timeframe?	7
Of chronic care encounters observed, how many were considered unstable patients?	1
Of the unstable patients observed, how many were completed within the appropriate timeframe?	1
Of the chronic care encounters observed, how many had a treatment plan?	7
Chronic Care Encounters Findings	1) BEST PRACTICE: Provider chronic care visits are based on the primary provider model. Provider primary care model is based on the last two A#'s. 2) One APP is missing from the list. Review of workloads support that the O-5 billeted APP dooes not have an active caseload.
Chronic Care Encounters Deliverables	1. Site to update the APP distribution list to include all APPs by 09/21/2019 and forward plan to RHSA for review. 2. HSA to monitor staff workloads and provide APP daily averages for workloads for the month of August. Submit to RHSA by 11/01/2019.

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Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	25
Of the general consent forms reviewed, how many were complete?	25
Of the consent forms reviewed, how many were dental consent forms?	11
Of the dental consent forms reviewed, how many were complete?	11
Of the consent forms reviewed, how many were psychotropic consent forms?	2
Of the psychotropic consent forms reviewed, how many were complete?	2
Consent Forms Findings	None
Consent Forms Deliverables	None

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	20
Of the daily assignment sheets reviewed, how many were archived appropriately?	20
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	6
Daily Assignment Sheets Findings	The facility does not complete the assignments sheets to include emergency teams consistently. While at site reported that they use badges to provide a visual of who is on emergency response teams. Great idea, but is not consistently being used. Staff report is not used to inform team of assignments so only a few staff were able to state who the responders were for the day. Daily assignmments are saved each shift into PDF docs on the shared drive, but are not updates to reflect call out or AL. There does not appear to be a review by the administrative team prior to being stored. Nursing board is a best practice.
Daily Assignment Sheets Deliverables	(b)(5)

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Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	No
Diagnostic Services Findings	Dosimeters are stored in individual desks. Unable to locate one dosimeter during survey.
Diagnostic Services Deliverables	(b)(5)

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	No
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	1. Man down drills were completed on 2 of 3 shifts. Ensure that three drills are performed each month. 2. Disaster drill from 2018 did not have a full assessment to indicate stregths and weaknesses. Upcoming disaster drill (Nov 2019) will utilize IHSC generated form, this no CAP for this item. 3. No evidence of dissemination of findings from drills to staff. 4. Trauma bags with expired supplies and secured without replenishing par levels x 4 days. Poor tracking and accountability of trauma bag use and

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	inventory. 5. Live ERT drill showed a lack of team cohesion or familiarity with team approach (leader, scribe, etc)
Emergency Preparedness and Response Deliverables	1. Three drills per month will be performed. Provide evidence of compliance to the RHSA by 10/01/2019. 2. Ensure that drills (SWOT) are incorporated into the monthly staff meetings. Provide evidence to HSA by 10/01/2019. 3. Revamp Trauma bag inventory, update inventory list (monthly audit vs inventory restock; include exp dates for all inventory that has a shelf life), revamp process of managing checks on the bags (daily, monthly and updates after being opened). Provide evidence of completion to RHSA by 10/01/2019.

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	No
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	SDS are located in nursing office. 3 are in bright yellow binders and a 4th white binder also exists. Staff unfamiliar with the binders or the difference between the white vs yellow SDS binders. There is no eveidence that the binders are reviewed annually. Nurse manager was unable to provide evidence of the daily, quarterly or annual chacklist.
Environmental Health Deliverables	(b)(5)

Grievances - Review Complete

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Number of medical grievances reported through QI/JIC/CRCL/DRIL.	17
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	3
Number of formal grievances.	7
Number of informal grievances.	0
Grievances Findings	Designated grievance officer has transitioned several times over the past year. Logs were current, but incomplete and unable to assess if 3/7 entries were completed within the 5 days. Outcomes refelected that grievances were investigated and outcomes at times substantiated. There was a significant decrease in the number of grievances as compared to the previous year. The site reports that they determine if written grievances "count" as a grievance and if not that it is not logged.
Grievances Deliverables	(b)(5)

Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	1
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	1
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	0
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	0

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Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	0
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	0
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	1
Hunger Strike Records Findings	Hunger strike reviewed was not in the 3 month timeframe indicated, but due to process issues noted, the review was added. Although, documentation of input and output was noted, the use of the template in eCW was incosistent. The pt remained on HS until he was transferred from the facility. Thus, the following questions were not applicable: 1) Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form? 2) Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours? 3) Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician? 4) Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart? The patient was refusing vital signs and assessment; As a result, no orthostatic vitals, vitals, or weights were assessed.
Hunger Strike Records Deliverables	None.

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	0
Of the patients on a hunger strike, how many were offered meals?	0
Of the patients on a hunger strike who were offered food, how much food was offered?	N/A
Of the food offered, how much of the food was eaten?	N/A
Of the patients on a hunger strike, how many had special needs?	0
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	N/A-No detianees on hunger strike during observation period.
Hunger Strike Encounters Deliverables	N/A

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Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	Policy followed.
Infectious Disease Prevention Deliverables	(b)(5)

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	9
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	9
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	16
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	0
Of the records with a pain scale greater than 0, how many were assessed?	0
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	6
Of the intake records with clinically significant findings, how many were referred appropriately?	6
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	4
Intake Screen Records Findings	Of the 25 intake records reviewed, eight (8) were conducted by a LVN or LPN, thus requiring the review of a RN or higher within 24 hours. Of those eight (8) records, four (4) did not meet that

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	requirement. Additionally, there were two records reviewed where, potentially, eCW template defaults were not changed to reflect the patient's answers or conditions. - In one record, the patient had a history of being sexually abused by their hsuband within the past six months. They were appropriately referred to mental health, but their intake screening was still coded as "normal." - In the other record, during the intake a patient had a rash and itching in their genital area. They were seen two weeks later for follow-up of this problem. Their intake screening was still coded as "normal."
Intake Screen Records Deliverables	(b)(5)

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	11
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	2
Of the intake screen encounters observed, how many included a full set of vital signs?	11
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	11
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	11
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	11
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	11
Intake Screen Encounters Findings	The nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening for TWO patients. This is NOT a negative finding as there was only TWO patients who arrived with this information.
Intake Screen Encounters Deliverables	No recommendations

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25

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Of the language access records reviewed, how many addressed and documented the use of a translator?	25
Of the language access records reviewed, how many did not use a translator?	13
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	12
Language Access Records Findings	No significant findings.
Language Access Records Deliverables	None

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	I speak posters are in both holding cells and in the intake area. The posters in the holding area are very small and very visible due to size and location.
Language Access Encounter Deliverables	(b)(5)

Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	4
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	2
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
	No

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Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	
Log Books Findings	Pharmacy had two refridgerator entries not signed. Failure was related to a TDY staff covering the pharmacy and omitting that step. Logs were maintained in paper format and would benefit from moving towards an electronic format.
Log Books Deliverables	1. Failure was related to a TDY staff covering the pharmacy and omitting that step. No further action required. 2. TEAM to review all logs related to emergecy preparedness and counts to ensure best methodologies are employed. Any audits should be reflected on the actual "count" sheet. Provide RHSA SWOT analysis and any log updates developed and implemented; submit by 11/01/19.

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	15
Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	15
Of the medication administrations observed, how many mouth checks were conducted?	15
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	15
How many MAR entries were observed?	15
Of the MAR entries observed, how many were complete?	15
Of the MAR entries observed, how many medication refusals were documented?	0
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	0
Of the identified medication refusals, how many were high-risk medications?	0
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	0
Medication Administration Findings	Patient identification was suboptimal and heavily relied on the patient ID. Patient was not active in the identification process. Minimal patient engagement in medication administration process. The pill-line nurse was also responsible for dispensing KOP and recieving requests for KOP refills.
Medication Administration Deliverables	1. Patient ID training to be performed by 10/01/2019 to include the best practice of patient involvement in the process. Forward the RN attendance roster to the RHSA as evidence of completion. 2. No refusals observed. Reviewed a random selection of resusal forms from July. It appears that the medication refusals are completed

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without the patient present as 100% of the refuals were annotated as patient refused to sign. It is unclear if the patient was present for the process. Informal recommendation: Review process and policy with staff to ensure intent of policy is being followed. 3. NM to perform a chart review of refusals to ensure patient encounters are entered on the 10 refusals reviewed during the survey and provide HSA and RHSA findings and CAP if indicated. Forward to RHSA by 10/15/2019.

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	0
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	0
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	Due to loss of FHPM the PHSP and QI quarterly meetings were not completed or available for review. Staff meetings were adequate - informal recommendation- update to include monthy updates on safety. emergency preparedness (Drills -SWOT) and CQI initiatives.
Meetings Deliverables	(b)(5)

MHU Full Admission Chart Review - Review Complete

How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	14
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	17
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	7
Of the MHU full admission records reviewed, how many had a nursing care plan?	2
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	2
Of the MHU full admission records reviewed, how many had patient education provided daily?	25

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Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	6
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	6
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	19
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	0
MHU Full Admission Records Findings	1) 11 of the 25 charts did not have the admission orders documented via eCW MHU Admission template (especially the mental health cases) 2) Only 1 chart was identifed as not having the PE completed within 24 hours of the MHU admission (MHU admission on 5/3/19 and PE completed on 5/7/19) 3) Only 2 of the 25 charts had nursing care plans; however detainees were educated daily on condition/treatment 4) One chart without mental health diagnosis and not assessed every 30 days by a BHP was identified.
MHU Full Admission Records Deliverables	(b)(5)

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	No
How many nurses are in the MHU full admission at the time of observation?	1
How many patients are in the MHU full admission at the time of observation?	1
How many MHU full admission patients have a 24-hour chart review everyday?	0
Of the MHU full admission records, were 24-hour charts completed appropriately?	None
How many MHU full admission patients have medications?	1
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	1
MHU Full Admission Encounters Findings	(b)(5)

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(b)(5)

MHU Full Admission Encounters Deliverables

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	12
Of personnel and credentialing files reviewed, how many were PHS officers?	3
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	0
Of personnel and credentialing files reviewed, how many were federal civil service employees?	0
Of personnel and credentialing files reviewed, how many were contractors?	9
Of personnel and credentialing files reviewed, how many records are for privileged staff?	1
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	1
Of the LIP staff records reviewed, how many had personnel files records current?	1
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	1
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	12
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	12
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	12
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	8

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Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	9
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	1
Of the staff records reviewed, how many had scope of practice documentation if applicable?	12
Personnel and Credentialing Files Findings	Credential folders were maintained exceptionally well. PHS officers did not have CV or COERs on file please ensure that the onboarding documents are printed and filed accordingly. No process in place to have performance appraisals included in the credential folders.
Personnel and Credentialing Files Deliverables	(b)(5)

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	15
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	15
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	14
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	3
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	5
	14

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Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	
Of the physical exam charts reviewed, how many were for adult females?	4
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	4
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	4
Physical Exam Records Findings	MD Chronic Care review has a compliance of 50%.
Physical Exam Records Deliverables	(b)(5)

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	4
Of the physical exam encounters observed, how many included a full set of vital signs?	4
Of the physical exam encounters observed, how many were completed within the specified timeframe?	3
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	0
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	0
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	4
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	4
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	4
Physical Exam Encounters Findings	

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	One PE Complex was performed at the 4 day mark. This was rectified upon notification. Lead APP distributes PE-C workflow for APPs to include distribution of appointments from intake. Most intakes identified as a PE-C are seen th same day. BEST PRACTICE RECOMMENDATION: Consider reviewing the unassigned PE-Cs within eCW daily to ensure that all PEs are performed within 48 hours per policy.
Physical Exam Encounters Deliverables	No recommendations for deliverables. Track and trend compliance of PE-C visits locally.

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	11
Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	No
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	11
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	11
Prescreen Encounters Findings	RN did not utilize interpreter services, but spoke to the patients in Spanish. Unable to determine the proficiency of the RNs Spansish. Patients with a language barrier were identified and pre-screening questions were completed with intake to verify responses. RN did not ask all pre-screening questions.
Prescreen Encounters Deliverables	(b)(5)

Risk Management - Review Complete

Trends	Trends June-July 2019: 3-low risk, 1-no process vulnerability, 2-pending determination
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	1
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	6
List all corrective actions identified in the preceding field and note their status and due dates.	Completion of action items pending. Due July 2019 to the MQMU RCS
Risk Management Findings	RCA action items pending. Site to follow up with Regional Compliance Specialist for follow up

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Risk Management Deliverables	RCA action items pending. Site to follow up with Regional Compliance Specialist for follow up

Schedules - Review Complete

How many schedules were reviewed?	3
Of the schedules reviewed, how many had a legend to explain codes?	3
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	3
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	3
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	3
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	No
Schedules Findings	Schedules are PDF'ed several times per month. It does not appear that all changes are made in red font and PDF'ed each time a change is made. Encourage that the schedule is also PDF'ed when initially posted and at the time in which the schedule has ended.
Schedules Deliverables	None

Segregation Chart Review - Review Pending

How many segregation records were reviewed?	25
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	25
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	21
Of the segregation records reviewed, how many offered the patient daily sick-call services?	25
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	25
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	4
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	10
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	4
Segregation Records Findings	

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	Num_NonMH: 4 Yes 21 N/A - Reviewer determined N/A if detainee was in segregation < 30 days Num_MHWeekly: Yes 3 No 4 N/A - Reviewer determined N/A if detainee in segregation < 1 week.
Segregation Records Deliverables	No data reported

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	25
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	Nurse observed performing rounds in segregation. Documenation noted and correctly completed on the segregation sheet (i.e. signature/print/time). BEST PRACTICE RECOMMENDATION: 1) Consider utilizing the medical examination room to assess all sick call complaints to appropriately document needs via RN sick call documention. 2) Ensure that all needs are assessed and addressed when performing rounds. The RN asked general questions such as are you ok and do you need anything, but specific questions were not asked (i.e. pain was not cosistently assessed with every patient, MH needs and status not consistenly asked). Brave 500 (female seg) does have a medical treatment room available with a computer and phone available. Medical supply room is available for restocking needs but it is not being utlized.
Segregation Encounters Deliverables	(b)(5)

Shift Report and Time Cards - Review Complete

Are shift reports conducted?	No
Is there at least one representative from each department?	No
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	No

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Shift Report and Time Cards Findings	Shift reports are not held twice per day as is customary. Morning shift report is held and is multidisciplinary. A second hand off is performed nurse-to-nurse at 1900. Time cards are utilized and staff punch in and out for lunch. 20 timecards reviewed. 4 hand hand written entries without any verification (initials by the HSA). One staff member routinely hand writes there lunch break on their card instead of punching in and out.
Shift Report and Time Cards Deliverables	(b)(5)

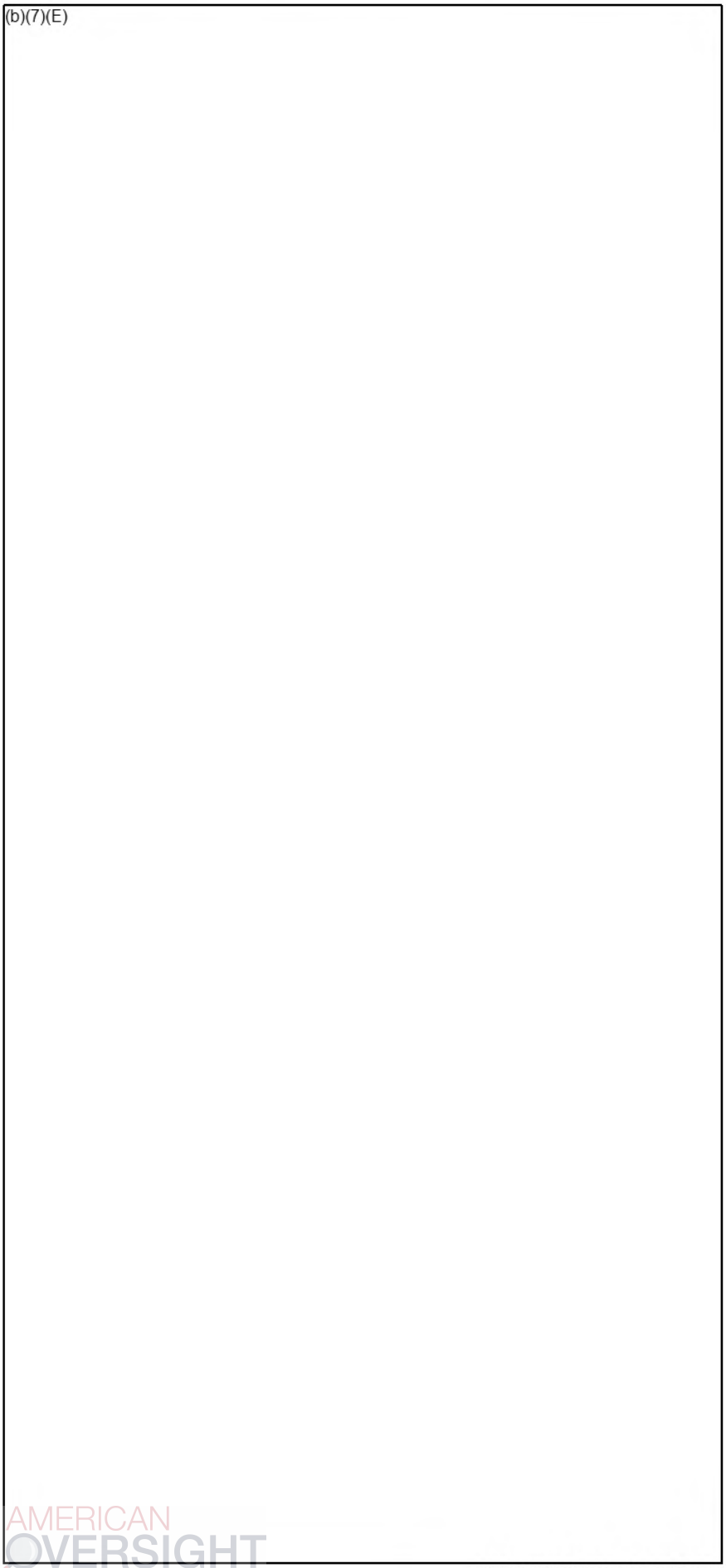
Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	1
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	1
Of the sick call records reviewed, how many included a full set of vital signs?	25
Of the sick call records reviewed, how many had a pain scale greater than 0?	10
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	10
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	22
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	24
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	20
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	19
Does the facility have a defined process in place addressing sick call services?	Yes
Sick Call Records Findings	Four encounters were address by the APP. Two encounters the nurse didn't use the pain scale.
Sick Call Records Deliverables	No deliverables required.

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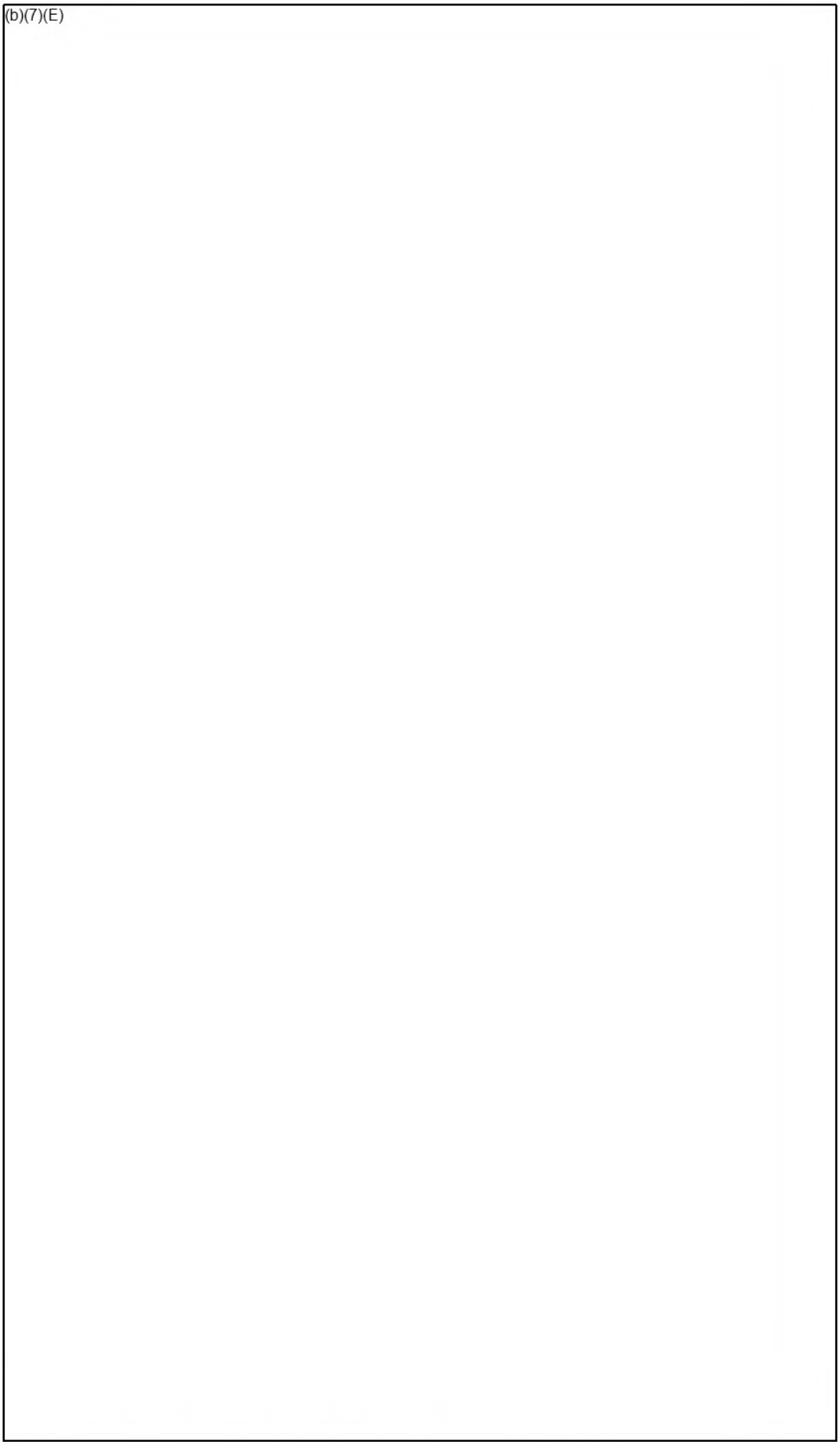
Staffing Information - Review Complete

(b)(7)(E)



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(b)(7)(E)



Suicide Watch Chart Review - Review Complete

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(b)(7)(E)

How many suicide watch records were reviewed?	
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	3
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	3
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	3
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	3
Of the suicide watch records, how many had a patient released from suicide watch?	3
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	3
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	3
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	3
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	3
Suicide Watch Pre-Audit Findings	No findings
Suicide Watch Pre-Audit Deliverables	No deliverables to report

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	0
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	0
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	0
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	0
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	0
Suicide Watch Encounters Findings	The site did not have patients on suicide watch during this observation.
Suicide Watch Encounters Deliverables	No recommendations

Training - Review Complete

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How many training folders were reviewed?	12
Of the training folders reviewed, how many had a HSD-500?	12
Of the training folders reviewed, how many had a signed position description ?	12
Of the training folders reviewed, how many were registered nurse training folders?	5
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	3
Of the training folders reviewed, how many had continuing medical education credits documented?	12
Training Findings	Two RNs did not have PE competencies in records.
Training Deliverables	(b)(5)

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	20
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	0
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	4
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	1
Transfers Findings	Transfer summary says chest x-ray negative even though it was positive and patient was being treated for presumptive TB General Transfer Summary: 5/25 did not have chronic medical conditions listed within the transfer summary. 100% in all other areas of review.
Transfers Deliverables	No deiverables identoified.
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	20
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	25

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Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	No
How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	12
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	12
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	8
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	10
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	Twelve records reviewed. Two PHS staff did not have fit test clearance or testing results in the files. STGi has not been submitting the clearance (2) at the time of hore or testing. Files are maintained seperately but are in an unlocked file cabinet in an office that is typically locked when administrators are not present. Files are well organized and an up to date tracker in place to ensure compliance.
Workforce Health Files Deliverables	(b)(5)

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Leadership Review

Facility	Houston
Start Date	2017-11-27
End Date	2017-12-01
Status	Leadership Review
Corrective Action Required?	No
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	NaN
Specialist, MQMU	(b)(6); (b)(7)(C)

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Pending Report Completion
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Pending Report Completion
DAD, Health Care Compliance Review Status	Pending Report Completion
DAD, Health Systems Support Review Status	Pending Report Completion
Chief of Staff Review Status	Pending Review
AD, IHSC Review Status	Pending Report Completion

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1000.00
MHU Beds	16.00
Daily Adult Male Population	806.00
Daily Adult Female Population	125.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	44.00
Comments	NO DATA

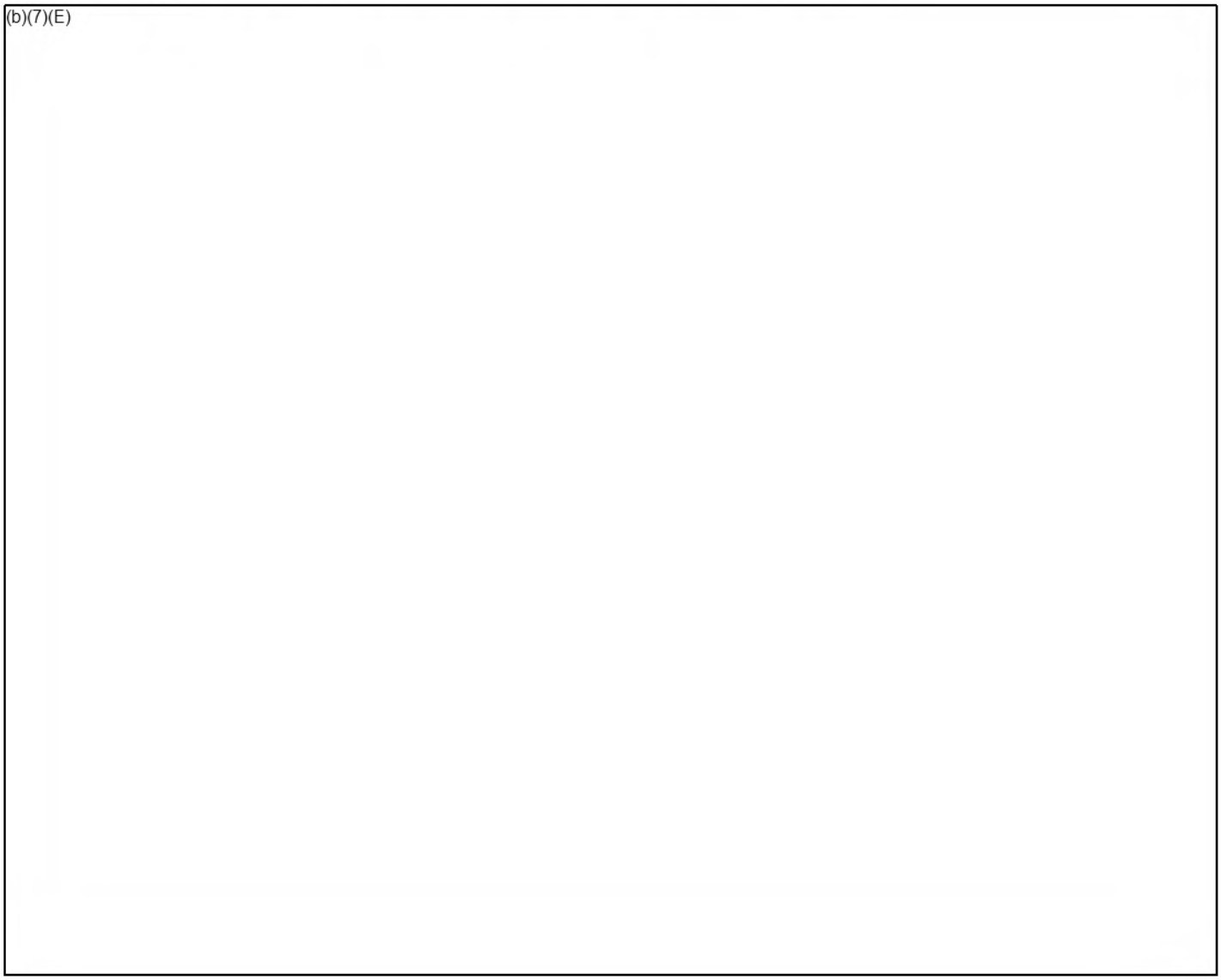
Average Number of Encounters (Past 3 Months)

Prescreenings	1186.00
Intake Screenings	1200.00
Physical Examinations	509.00
Vitals/Labs	1633.00
Sick Call	624.00
Pros/Imm	73.00
Acute	58.00
Chronic	96.00
Mental Health	252.00
Dental	121.00
Emergent/Urgent	23.00
MHU	750.00
Segregation	455.00
Admin	32.00
Transfers	1077.00
Pill-Line Passes	21930.00
Prescriptions (Pill-line + KOP)	1840.00
Referrals/ER	61.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)



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Accreditation - Review Complete

Last ACA Accreditation	2016-10-26
Last ACA Findings	Last ACA- October 26-27, 2016. No issues identified; facility found compliant in 100% of all applicable mandatory and non-mandatory standards.
Last NCCHC Accreditation	2014-10-27
Last NCCHC Findings	Last NCCHC survey conducted October 27-28, 2014. The facility was found in compliance with 100% of its applicable essential standards, and 92% of its applicable important standards. They were awarded re-accreditation.
Last PBNDS Accreditation	2017-01-17
Last PBNDS Findings	No medical findings.
Comments	NO DATA

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	0.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	0.00
Number of informal grievances.	4.00
Findings	None
Deliverables	None

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Risk Management - Review Complete

Trends	No concerning trends.
Number of active RCAs/SOEs	0.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	NO DATA
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	4.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	1.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	One patient refused HTN meds.
Deliverables	None

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	No - See findings below.
Do emergency scenarios vary?	No - See findings below.
Is the difference between a drill and an actual event evident in the write-up?	No - See findings below.
Do all staff participate in the drills?	Yes
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	N/A - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	Scenarios were copy/paste the last three months. The only thing that was changed was the age of the individual by 2 years.
Deliverables	(b)(5)

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Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	N/A - See findings below.
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	None
Deliverables	None

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	9.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	9.00
Number of psychotropic consent forms among the identified consent forms.	10.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	10.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	All dental and Psychotropic visits reviewed had consent forms on file
Deliverables	NO DATA

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	21.00
Out of the transfers reviewed, how many had a positive chest X-ray?	4.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	0.00
Out of the transfers reviewed, how many have active TB?	1.00
Out of the transfers with active TB, how many are not being treated for TB?	1.00
Number of transfers with chronic medical conditions or lack thereof annotated.	12.00
Number of transfers with medication instructions clearly provided.	12.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) Transfer summary indicates "Is detainee being treated for active TB disease?" No. However, detainee is confirmed Active TB and is being treated with TB medications and no mention of TB-CM attached. (b)(6); (b)(7)(C) transfer summary indicates "TB Screening Modality: CXR but does not indicate a date or results of the CXR. Actual CXR results as documented in eCW indicated on 5-30-17 "Positive screening for Active TB disease by radiographic criteria". Patient was not worked-up for TB rule-out. (b)(6); (b)(7)(C) Transfer summary indicates "CXR Results 5-15-17 Negative; not consistent with TB"; however CXR as indicated in "Past Medical History" as "Positive screening for Active TB" for same date. Actual CXR result was positive. Also, transfer summary indicates "No treatment for TB"; however transfer summary lists RIPE treatment under "Current Medications" (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) transfer summary indicates detainee not

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	being treated for Active TB, however "Current Medications" include RIPE mediations.
Deliverables	NO DATA

Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	20.00
Number of prescreens that used a translator.	10.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	10.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	15.00
Number of prescreens with documentation completed in eCW prior to intake screening.	8.00
Findings	Of the 25 pre-screens reviewed, 17 had documentation completed in eCW AFTER the intake screening documentation was completed in eCW. Of the 25 pre-screens reviewed, 20 were triaged per pre-screen policy; five (5) were not.
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	11.00
Number of prescreen encounters observed that allowed for patient privacy.	8.00
If privacy was not provided, where was the prescreen performed?	See below
Number of prescreen encounters that used language services.	8.00
Number of prescreen encounters completed within two hours of arrival.	0.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	0.00
Number of prescreen encounters prioritized.	0.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	0.00
Findings	Prescreens were conducted the same time as intake screening. Detainees arrived in the facility at 0600, but as of 11:40 am there no prescreen or intakes initiated. Privacy concerns where the door open with other detainees within 7 feet of the intake room.
Deliverables	(b)(5)

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	23.00
Of the intake records reviewed, how many used a translator?	5.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	5.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	12.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	24.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	10.00
Of the intake screening records, how many were TB positive?	1.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	0.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	0.00
Number of intake screenings with mental health screening completed.	23.00
Number of intake screenings that used the eCW Intake Screening template.	23.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	23.00
Number of intake screenings with clinically significant findings.	6.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	6.00
Number of intake screenings reviewed by an RN or above within 24 hours.	0.00
Findings	25 Intake charts reviewed; on six (6) of them, the person conducting the intake screening put "Self" for Interpreter Name or Number, for Intake Screening they conducted. Since the person conducting the intake screening did not utilize someone else for interpretor services, I have checked this encounter as a "no" for an interpretator being utilized. Recommend re-training/education to staff on appropriate notation when they do not seek another colleague, or the Language Line, for interpreator services. "Provider fluent in detainee's language" should have been selected for these intakes. On two (2) intake screenings reviewed- Appropriate e-CW template for intake screening not utilized. Not able to evaluate whether a translator was used, whether the detainee's language was identified, whether a mental health screening was completed, etc. due to those questions not being on these intakes. Out of the 25 Intakes reviewed, there was one TB positive pation. There is documentation of TB status within record (detainee was TB positive) but the documentation was not signed, dated and stamped by an RN or higher. For 13 charts reviewed- There is documentation of TB status within record (detaine was TB negative) but the documentation was not signed, dated and stamped by an RN or higher For one (1) chart reviewed- there was TB documtation in the record, but the TB documentation did not state whether detainee was negative or positive. Since there was no evidence elsewhere in the record that the detainee was positive, assumed the detainee was negative. This documentation was not signed, dated and stamped by a RN or higher. For one (1) chart reviewed, the intake screening was conducted by a LVN, but the intake screening was not reviewed by a RN or higher within 24 hours. There is no evidence/documentation of review by a RN, on the intake screening.
Deliverables	NO DATA

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Intake Screening Observations - Review Complete

Number of intake screenings observed.	11.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	0.00
Number of intake screening observations where a full set of vital signs were taken.	11.00
Number of intake screening observations that used language services.	8.00
Of the intake screening observations that used language services, how many were appropriately conducted?	8.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	0.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	8.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	Same as prescreen findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	24.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	24.00
Number of chronic care encounters with medications.	23.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	23.00
Number of chronic care encounters with psychiatric medications.	4.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	4.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	4.00
Number of chronic care patients identified as stable.	15.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	15.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	15.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	25.00

Findings

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	(b)(6); (b)(7)(C) Chronic appointment pending and unlocked for 6/12 (b)(6); (b)(7)(C) Chronic appointment pending and unlocked for 6/12, no global alert (b)(6); (b)(7)(C) Chronic appointment pending and unlocked for 6/16, no global alert A# (b)(6); (b)(7)(C) no global alert (b)(6); (b)(7)(C) - no global alert A (b)(6); (b)(7)(C) no global alert A# (b)(6); (b)(7)(C) Unlocked telephone encounter 6/7 and 6/8, chronic appointment pending and unlocked 6/13. (b)(6); (b)(7)(C) - no global alert (b)(6); (b)(7)(C) - no global alert, BP check to be scheduled on 5/23/17, no check ever completed (b)(6); (b)(7)(C) PE-C not completed in 48 hours (b)(6); (b)(7)(C) - no global alert (b)(6); (b)(7)(C) - no global alert A# (b)(6); (b)(7)(C) - no global alert (b)(6); (b)(7)(C) - 5 1/2 months between PR-C and chronic appointment 11/25/16 to 05/08/17
Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	0.00
Number of chronic care encounters observed that utilized language services.	0.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	0.00
Findings	APPs were not able to see Chronic Care patients due to the amount of sick calls, fall outs, and PE-Cs from intake.
Deliverables	(b)(5)

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	6.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	6.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	1.00
Of the physical examinations with pain assessment, how many were addressed?	1.00
Number of physical examinations with clinically significant findings.	25.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	25.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	8.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	MDs should review PE-C within 7 days.
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	6.00
Number of physical examination encounters with a full set of vital signs taken.	6.00
Number of physical examination encounters observed that were completed within 14 days.	6.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	6.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	6.00
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	3.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	4.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	24.00
Number of sick call encounters with a pain scale greater than 0.	16.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	15.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	11.00
Number of sick call encounters where the reason is documented in the "Reason" field.	16.00
Number of sick call encounters where the reason for the visit was from an approved category.	25.00
Number of sick call encounters addressed by a nurse.	8.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	16.00
Findings	NO DATA
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	N/A - See findings below.
Findings	None
Deliverables	None

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	4.00
Number of MHU 23 hour observation records with discharge encounters.	4.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	4.00
Number of MHU 23 hour observation records with telephone order admission.	2.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	0.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	1) the 2 MHU 23 hour observation records with telephone order admissions did not have a telephone encounter generated/routed to the provider 2) None of the four 23 hours Observation Admission notes were not labeled as Observation
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	NO DATA
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	0.00
Number of MHU full admission records reviewed.	25.00
Number of MHU full admission records with admission encounters.	18.00
Number of MHU full admission records with discharge encounters.	11.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	25.00
Number of MHU full admission records with no PE within the past year.	25.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	0.00
Number of MHU full admission records with acuity level assigned.	18.00
Number of MHU full admission records with all medications placed on pill line.	23.00
Number of MHU full admission records with 24 hour chart reviews everyday.	25.00
Number of MHU full admission records for patients in segregation for medical overflow.	1.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	1.00
Number of MHU full admission records with a nursing care plan.	0.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	0.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	25.00

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Number of MHU full admission records with mental health diagnoses.	4.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	4.00
Number of MHU full admission records without mental health diagnoses.	21.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00
Findings	1) 7 charts noted without MHU admission note 2) 2 charts noted without MHU discharge note and the remainder 7 are not counted as having discharge summary because the patients are presently admitted to the MHU. 3) because of not completing an admission note during MHU Admission the acuity level was not assigned 4) 23 charts had medications ordered via pill line the remainder did not have any medications ordered as clinically indicated 5) Unable to locate any Nursing care plans to review them (checked the scanned documents with both patients currently admitted and those who have been discharged and still unable to locate/reviewed any Nursing care plans) 6) 4 charts of patients who were admitted to the MHU for over 30 days without any mental health diagnosis did not have any Mental Health assessments every 30 days.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	5.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	4.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	4.00
Number of suicide watch records where the need for finger foos was annotated.	4.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	4.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	4.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	4.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	5.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	5.00
Findings	This reviewer only found 5 charts. Recommend (b)(5)
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	1.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	1.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	1.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	1.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	1.00
Findings	None
Deliverables	None

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Hunger Strike - Review Complete

Number of hunger strike records reviewed.	1.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	1.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	1.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	1.00
Number of hunger strike records with special needs.	0.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	0.00
Findings	One chart found, Detainee refused vital signs.Recommend reviewing HS policy to include review of the need for documentation of I/OS
Deliverables	NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	19.00
Number of segregation records where daily segregation rounds by nursing are documented.	22.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	22.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	25.00
Number of segregation records where the patient was seen weekly by mental health.	24.00
Findings	(b)(6); (b)(7)(C) Preclearance completed, daily seg rounds and sick call completed, MH saw 4/25. Detainee threatened hunger strike on 4/25. Seen by mental health, no further notes made regarding hunger stike or resolution.(b)(6); (b)(7)(C) - Daily seg rounds and sick call not completed on 6/10 A# (b)(6); (b)(7)(C) Preclearance not completed (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Preclearance not completed (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Preclearance completed, detainee hypertensive, tachcardic, and wheezing, no referral or follow up completed to reevaluate detainee. A# (b)(6); (b)(7)(C) Preclearance not completed A# 079- (b)(6); (b)(7)(C) Daily seg rounds and sick call not completed on 4/2 and 6/10 (b)(6); (b)(7)(C) Preclearance not completed Preclearance not completed Daily seg rounds and sick call not completed on 6/10 A# (b)(6); (b)(7)(C) Preclearance completed, detainee hypertensive, no referral or follow up completed to reevaluate detainee.(b)(6); (b)(7)(C) MH did not see detainee while he was in seg.(b)(6); (b)(7)(C) Preclearance not completed
Deliverables	NO DATA

AMERICAN OVERSIGHT

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	8.00
Number of after hours medication records with the patient's identification number documented.	8.00
Number of after hours medication records with medication order(s) documented in eCW.	8.00
Number of after hours medication records that were generated by a nurse as a telephone order.	6.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	0.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	Random count of six medications were conducted and three of the medications' count were not accurate.
Deliverables	NO DATA

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	Most of the meds are in bulk boxes.
Deliverables	(b)(5)

AMERICAN OVERSIGHT

Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	23.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	23.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	5.00
Reasons for why a translator was not used.	For those charts were a translator was not utilized, the following reasons where provided: 1. Not applicable- detainee speaks English 2. Provider fluent in detainee's/patient's language
Findings	Of the 25 charts reviewed- On six of them, the person conducted the Intake screening put "Self" for Interpreter Name or Number, for Intake Screening they conducted. Since the person conducting the intake screening did not utilize someone else for interpretor services, I have checked this encounter as a "no" for an interpretator being utilized. Additionally, recommend re-training/education to staff on appropriate notation when they do not seek another colleague, or the Language Line, for interpreator services. "Provider fluent in detainee's language" should have been selected for these intakes. On two of the charts reviewed- Appropriate e-CW template for intake screening not utilized. Not able to evaluate whether a translator was used, whether the detainee's language was identified, whether a mental health screening was completed, etc. due to those questions not being on these intakes.
Deliverables	NO DATA

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Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	None
Deliverables	NO DATA

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	3.00
Number of refridgerator temperature logs that are up to date.	3.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	None
Deliverables	None

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Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	40.00
Number of daily assignment sheets completed and archived .	40.00
Number of daily assignment sheets with one emergency team identified per shift.	40.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	40.00
Number of daily assignment sheets with clinic inspection completed and signed.	40.00
Are detainee referrals documented?	Yes
Findings	None
Deliverables	None

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	None
Deliverables	None

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	1.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	Staff Meeting for the month of October was not conducted. HSA conducted staff training in its place. Staff Meetings are required regardless of the need for training.
Deliverables	None

AMERICAN OVERSIGHT

Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	6.00
Number of federal civil service employee personnel files reviewed.	0.00
Number of contractor personnel files reviewed.	19.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	Yes
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	5.00
Of the personnel file records for priveleged staff, how many are current?	5.00
Number of personnel files with current and signed Health and Ability form.	25.00
Number of personnel files with a signed statement of confidentiality (one time).	25.00
Number of personnel files with a signed statement of risks and responsibility (one time).	25.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	25.00
Number of personnel files with a signed release of information form (one time).	25.00
Findings	1. Seven Yearly Nursing Competencies were expired. 2. RNs Yearly PE Authorization Assessments were expired (CD just returned from extended medical leave). Conduct a review of all personel files to insure compliance.
Deliverables	N/A

AMERICAN OVERSIGHT

Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	6.00
Number of federal civil service employee credentialing files reviewed.	0.00
Number of contractor credentialing files reviewed.	19.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	23.00
Number of credentialing files with current, valid, and unrestricted license.	23.00
Number of credentialing files with license primary source verification.	23.00
Number of credentialing files with documentation of primary education.	23.00
Number of credentialing files with education primary source verification.	23.00
Number of credentialing files reviewed for physicians or psychiatrists.	3.00
Number of physician or psychiatrist credentialing files with documentation of residency.	3.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	3.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	3.00
Number of credentialing files with a curriculum vitae or resume.	25.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	6.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	5.00
Number of credentialing files with scope of practice.	23.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	0.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	23.00
Number of peer reviews reviewed.	4.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	4.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	2 MRT files reviewed
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	25.00
Number of employee health files with current TB (PPD or CXR) documentation.	25.00
Number of employee health files with current Hepatitis B vaccination or declination form.	25.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	19.00
Number of employee health files with current respirator medical clearance.	23.00
Number of employee health files with current respirator fit test.	23.00
Number of employee health files with emergency contacts.	25.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	No - See findings below.
Findings	None
Deliverables	None

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Training - Review Complete

Number of training folders reviewed.	25.00
Number of training folders with HSD-500.	25.00
Number of training folders with a signed position description.	25.00
Number of registered nurse training folders reviewed.	14.00
Number of registered nurse training folders with RN Physical Exam Training.	14.00
Number of training folders with continuing medical education credits.	9.00
Number of training folders with BLS for health care providers or CPR and AED certification.	14.00
Number of radiation safetoy officer training folders with radiation safety training.	1.00
Findings	Seven RN Physical Exam Training are expired. Have CD update training.
Deliverables	None

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	N/A - See findings below.
Is hand hygiene monitoring conducted and documented?	Yes
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	1.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	1. Saving as "Revisons" for each time the scheduled is changed isn't being conducted. Going forward, each time a schedule is changed it must be saved, pdf'd, and label as revison number.
Deliverables	None

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
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Report generated: undefined
Report generated: undefined

Assessment Information - Report Complete

Facility	Houston
Site visit start date	2019-03-01
Site visit end date	2019-06-14
Fiscal Year	FY2019
Fiscal Quarter	Q2
Post-audit corrective action identified	No
Immediate corrective action identified	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Medical Quality Management Unit Review Status	Pending Report Completion
DAD, Health Care Compliance Review Status	Pending Report Completion

Facility Information - Review Complete

Facility HSA, AHSA, Nurse Manager, and FHPM	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1000

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MHU Beds	0
Daily Adult Male Population	750
Daily Adult Female Population	250
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	20
Facility Information Comments	Currently, Facility does not have Medical Housing Unit.

Average Number of Encounters (Past 3 Months)

Prescreenings	2459
Intake Screenings	2435
Physical Examinations	2038
Vitals/Labs	1894
Sick Call	2022
Pros/Imm	2022
Acute	579
Chronic	79
Mental Health	250
Dental	302
Emergent/Urgent	54
MHU	0
Segregation	699
Admin	60
Transfers	2508
Pill-Line Passes	697
Prescriptions (Pill-line + KOP)	1952
Referrals/ER	100

Accreditation - Review Complete

Last ACA Accreditation	2016-10-26T04:00:00Z
Last ACA Findings	None
Last NCCHC Accreditation	2018-02-14T05:00:00Z
Last NCCHC Findings	None
Last PBNDS Accreditation	2019-01-10T05:00:00Z
Last PBNDS Findings	Finding: Review of medical records confirmed that detainees who are identified as being "at risk" are immediately referred to a

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	behavioral health provider but are not always evaluated within 24 hours of referral. One of seventeen detainees on suicide watch since the last inspection was not evaluated by a mental health professional within 24 hours. This detainee was placed on suicide watch on a Saturday and was evaluated the following Monday, just outside the 24-hour window. Per the HSA, it is policy that a mental health provider is always on-call and will come on-site on weekends if needed. There was only one other weekend referral in the past year and documentation was reviewed that the mental health provider did come in and evaluate that detainee within 24 hours.
Accreditation Comments	Training completed and corrected for PBNDS finding.

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	29
Of the after hours med log records reviewed, how many records documented the patient's identification number?	28
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	15
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	13
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	Provider signed the telephone encounter outside of 24 hour return to work.
After Hours Medication Chart Review Deliverables	None

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	No
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
	Yes

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Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	
After Hours Medication Encounters Findings	Because after hours medications are taken out of the cart, medications are not ordered in eCW so patient does not recieve double dose of medication. Medications properly documented as given by nurse or provider when removed from cart.
After Hours Medication Encounters Deliverables	None

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	22
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	20
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	20
Of the chronic care records reviewed, how many detainees had psychiatric medications?	5
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	5
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	3
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	25
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	25
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	0
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	0
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	12
Chronic Care Records Findings	Global Alerts are not being set continuously within ECW. Also, Two detainees were seen in 96 days instead of the required 90 for MD or Psyc. encounter. Some PE-C's were not completed within 48 hours but seen the following day.

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Chronic Care Records Deliverables	Lead Provider instructed training on setting Global Alerts. Training roster obtained.

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	25
Of chronic care encounters observed, how many were considered stable patients?	25
Of the stable patients observed, how many were completed within the appropriate timeframe?	25
Of chronic care encounters observed, how many were considered unstable patients?	0
Of the unstable patients observed, how many were completed within the appropriate timeframe?	0
Of the chronic care encounters observed, how many had a treatment plan?	25
Chronic Care Encounters Findings	No findings
Chronic Care Encounters Deliverables	None

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	25
Of the general consent forms reviewed, how many were complete?	25
Of the consent forms reviewed, how many were dental consent forms?	3
Of the dental consent forms reviewed, how many were complete?	3
Of the consent forms reviewed, how many were psychotropic consent forms?	3
Of the psychotropic consent forms reviewed, how many were complete?	3
Consent Forms Findings	No Findings
Consent Forms Deliverables	None

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	25

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Of the daily assignment sheets reviewed, how many were archived appropriately?	25
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	25
Daily Assignment Sheets Findings	No findings
Daily Assignment Sheets Deliverables	None

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	No Findings
Diagnostic Services Deliverables	None

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	Yes
	Yes

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Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	
Emergency Preparedness and Response Findings	No findings
Emergency Preparedness and Response Deliverables	None

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	Yes
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	No findings
Environmental Health Deliverables	None

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	8
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	0
Number of informal grievances.	8
Grievances Findings	None
Grievances Deliverables	None

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Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	0
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	0
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	0
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	0
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	0
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	0
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	0
Hunger Strike Records Findings	there were no hungerstrike detainees from October 2018 through March 2019
Hunger Strike Records Deliverables	N/A

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	0
Of the patients on a hunger strike, how many were offered meals?	0
Of the patients on a hunger strike who were offered food, how much food was offered?	n/a
Of the food offered, how much of the food was eaten?	n/a
	0

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Of the patients on a hunger strike, how many had special needs?	
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	none
Hunger Strike Encounters Deliverables	N/A

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	None
Infectious Disease Prevention Deliverables	None

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	25
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	25
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	0
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	0
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	0
Of the records with a pain scale greater than 0, how many were assessed?	0
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	3
Of the intake records with clinically significant findings, how many were referred appropriately?	3

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Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	25
Intake Screen Records Findings	all 25 dteainees had documented that they stated that they were having no pain. so there was no pain to be assessed.
Intake Screen Records Deliverables	None

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	10
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	10
Of the intake screen encounters observed, how many included a full set of vital signs?	10
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	10
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	10
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	6
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	10
Intake Screen Encounters Findings	Watched 2 nurses complete the intake process . One nurse completed 4 of the ten and did not inform the detainees about the upcoming PE or the facility grievance process.
Intake Screen Encounters Deliverables	I notified the NM and she will be educating the nursing staff during the next nursing meeting and the HSA educated the staff at a shift reort of the need to educate the detainees during intake (pe's, grievances)

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	25
Of the language access records reviewed, how many did not use a translator?	0

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Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	0
Language Access Records Findings	none
Language Access Records Deliverables	None

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	None
Language Access Encounter Deliverables	None

Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	2
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	2
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	Yes
Log Books Findings	none
Log Books Deliverables	None

Medication Administration Observation - Review Complete

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Is prepouring occurring?	No
How many medication administrations were observed?	10
Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	10
Of the medication administrations observed, how many mouth checks were conducted?	10
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	10
How many MAR entries were observed?	10
Of the MAR entries observed, how many were complete?	10
Of the MAR entries observed, how many medication refusals were documented?	0
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	0
Of the identified medication refusals, how many were high-risk medications?	0
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	0
Medication Administration Findings	None
Medication Administration Deliverables	None

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	2
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	None
Meetings Deliverables	None

MHU Full Admission Chart Review - Review Complete

How many MHU full admission records were reviewed?	No data reported
	No data reported

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Of the MHU full admission records reviewed, how many had admission encounters?	
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	No data reported
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	No data reported
Of the MHU full admission records reviewed, how many had a nursing care plan?	No data reported
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	No data reported
Of the MHU full admission records reviewed, how many had patient education provided daily?	No data reported
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	No data reported
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	No data reported
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	No data reported
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	No data reported
MHU Full Admission Records Findings	Facility does not have an Medical Housing Unit at this time.
MHU Full Admission Records Deliverables	N/A

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	No data reported
How many nurses are in the MHU full admission at the time of observation?	No data reported
How many patients are in the MHU full admission at the time of observation?	No data reported
How many MHU full admission patients have a 24-hour chart review everyday?	No data reported
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	No data reported
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	No data reported

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MHU Full Admission Encounters Findings	Facility does not have an Medical Housing Unit at this time.
MHU Full Admission Encounters Deliverables	N/A

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	12
Of personnel and credentialing files reviewed, how many were PHS officers?	6
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	6
Of personnel and credentialing files reviewed, how many were federal civil service employees?	0
Of personnel and credentialing files reviewed, how many were contractors?	6
Of personnel and credentialing files reviewed, how many records are for privileged staff?	2
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	1
Of the LIP staff records reviewed, how many had personnel files records current?	1
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	1
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	12
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	12
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	12
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	12
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1

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Of the physician or psychiatrist records, how many had documentation of residency?	0
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	1
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	3
Personnel and Credentialing Files Findings	Assuming that the term "Documentation of Primary Education" mean documentation and verification of initial degree, all 12 folders meet this requirement. If the statement is refering to Primary Education as it relates to schooling as a child,none of the 12 Folders contained that information. The Personnel folders are tracked eletranically: The contract personnel and federal personnel are tracked and mainted separately
Personnel and Credentialing Files Deliverables	None

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	16
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	16
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	15
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	3
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	25
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	22
Of the physical exam charts reviewed, how many were for adult females?	4

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Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	4
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	2
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	2
Physical Exam Records Findings	21 Male Charts Reviewed 4 Adult female charts reviewed. Of the 4 female charts 2 PE-S charted no indiction vaginal exam was notindicated, 1 PE-C a Pap was completed, 1 PE-C the patient refused the PAP. PEs that did not document language services indicated the patient spoke english
Physical Exam Records Deliverables	None

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	15
Of the physical exam encounters observed, how many included a full set of vital signs?	15
Of the physical exam encounters observed, how many were completed within the specified timeframe?	15
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	4
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	4
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	15
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	15
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	0
Physical Exam Encounters Findings	15 charts reviewed, the four charts with abnormal vitals signs were vitals of PE-Cs
Physical Exam Encounters Deliverables	None

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	15
	Yes

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Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	15
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	3
Prescreen Encounters Findings	No findings at this time
Prescreen Encounters Deliverables	None

Risk Management - Review Complete

Trends	No data reported
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	0
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0
List all corrective actions identified in the preceding field and note their status and due dates.	No data reported
Risk Management Findings	None
Risk Management Deliverables	None

Schedules - Review Complete

How many schedules were reviewed?	6
Of the schedules reviewed, how many had a legend to explain codes?	6
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	6
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	6
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	6
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	Salary is scheduled 40 hours a week. Hourly UAP 40 hours a week. Hourly Nurses 80 Hours every two weeks (averaging 40 hours a

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	week). Provider coverage is provided on Saturdaya and Holidays. RNs are scheduled based on need and often require schedulung for non-traditional shifts
Schedules Deliverables	None

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	15
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	15
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	15
Of the segregation records reviewed, how many offered the patient daily sick-call services?	15
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	15
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	14
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	1
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	1
Segregation Records Findings	No finding at this time
Segregation Records Deliverables	None

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	0
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	Currently we do Not have a functioning MHU
Segregation Encounters Deliverables	None

Shift Report and Time Cards - Review Complete

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Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	Yes
Shift Report and Time Cards Findings	Houston CDF is currently using electronically time cards.
Shift Report and Time Cards Deliverables	No findings

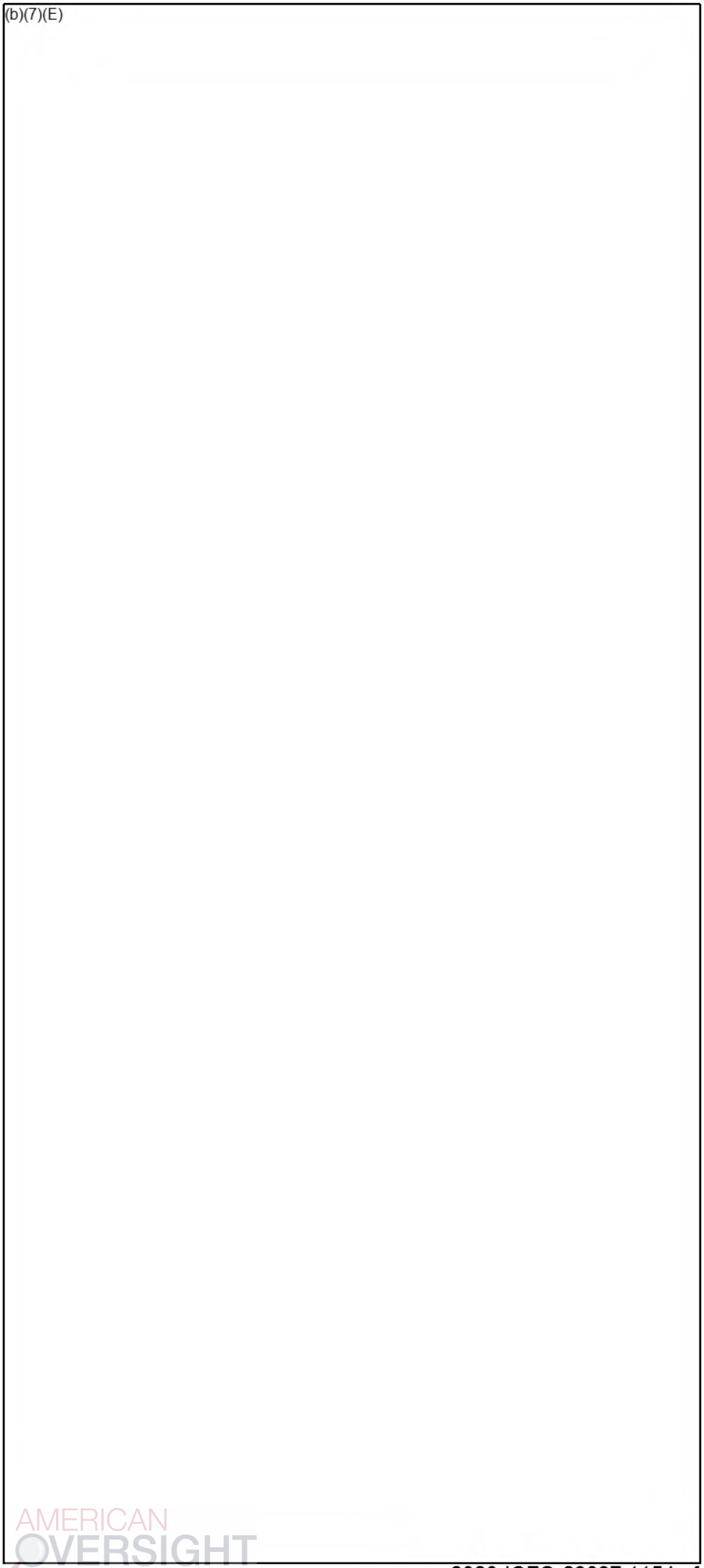
Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	2
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	2
Of the sick call records reviewed, how many included a full set of vital signs?	23
Of the sick call records reviewed, how many had a pain scale greater than 0?	14
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	14
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	22
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	25
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	22
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	22
Does the facility have a defined process in place addressing sick call services?	Yes
Sick Call Records Findings	2 out of 23 sick chart found without a full set of vital sign
Sick Call Records Deliverables	Re-edcuate and remind nurses to obtain a full set of vital sign for each encounter.

Staffing Information - Review Complete

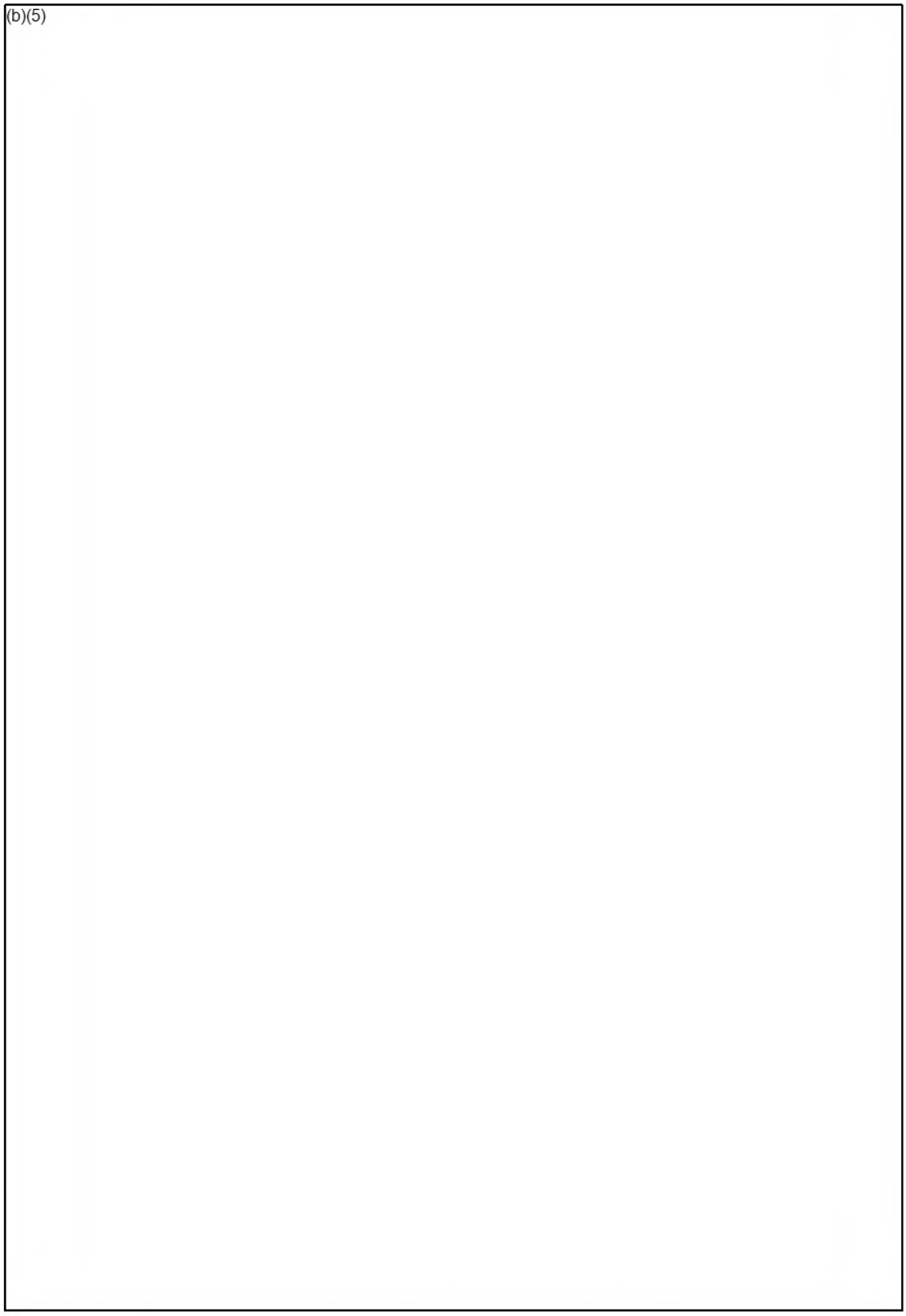
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(b)(7)(E)



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(b)(5)



Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed?	4
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	4
	2

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Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	2
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	4
Of the suicide watch records, how many had a patient released from suicide watch?	4
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	4
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	4
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	4
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	4
Suicide Watch Pre-Audit Findings	no special need form for finger food and suicide mock noted in 2 chart.
Suicide Watch Pre-Audit Deliverables	Notified and reminded the mental health providers to complete special need form for finger food and suicide mock for every suicide watch patient.

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	0
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	No data reported
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	No data reported
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	No data reported
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	No data reported
Suicide Watch Encounters Findings	No suicide watch observed during this health assessemtn.
Suicide Watch Encounters Deliverables	None

Training - Review Complete

How many training folders were reviewed?	25
Of the training folders reviewed, how many had a HSD-500?	25

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Of the training folders reviewed, how many had a signed position description ?	25
Of the training folders reviewed, how many were registered nurse training folders?	18
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	18
Of the training folders reviewed, how many had continuing medical education credits documented?	20
Training Findings	5 out of 25 folders do not have CEU credits
Training Deliverables	Remind staff to continue to complete their required CEUs and submit them to administrative staff for filing..

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	0
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	0
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	0
Transfers Findings	No Findings
Transfers Deliverables	None
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	6
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	6

Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes

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How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	12
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	12
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	12
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	no findings
Workforce Health Files Deliverables	None

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Year	Site	Explanation
FY 2017 only	• Stewart Detention Center	• Site closed in NOV 2018. Therefore, no reports were documented for **2019-2020**. Unable to not find a report for **2018** likely due to the site closing.
FY17-19 (Pending 2020 Onsite Assessment)	• South Texas Detention Complex (Pearsall) • Jena/Lasalle Detention Facility • Houston Contract Detention Facility	• Houston: missing **2018** report. An assessment was not completed due to a hurricane that damaged the facility. • **2020**: All three of these sites are scheduled for an onsite assessment in FY2020. Site visits are on hold pending reversal of travel restrictions.
FY17-19 (Pending 2020 Self-assessment Assessment)	• Eloy Federal Contract Facility (Eloy) • Northwest Detention Center (Tacoma) • Port Isabel Detention Center (PIDC) • Otay Mesa Detention Center (San Diego) • Florence Correctional Center • El Paso Service Processing Center	• **2020**: All six of these sites are scheduled for a self-assessment in FY2020. Self-assessment reports are due June 2020.

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Facility 1	Facility 2	Review Day	Review Date	Day of the Week	Task
Jena		**Day 1**	3/23/2018	**Friday**	**H.S.A. Coordinator to initiate the pre-audit (emails triggered to team members via SharePoint**
		Day 2	3/24/2018	Saturday	Weekend
		Day 3	3/25/2018	Sunday	Weekend
		Day 4	3/26/2018	Monday	Review of charts, documentation, previous audit results, etc. by all units
		Day 5	3/27/2018	Tuesday	Review of charts, documentation, previous audit results, etc. by all units
		Day 6	3/28/2018	Wednesday	Review of charts, documentation, previous audit results, etc. by all units
		Day 7	3/29/2018	Thursday	Review of charts, documentation, previous audit results, etc. by all units
		Day 8	3/30/2018	Friday	Review of charts, documentation, previous audit results, etc. by all units
		Day 9	3/31/2018	Saturday	Weekend
		Day 10	4/1/2018	Sunday	Weekend
		Day 11	4/2/2018	Monday	Team Lead & Assistant review of documentation in SharePoint
		Day 12	4/3/2018	Tuesday	Team Lead & Assistant review of documentation in SharePoint
		Day 13	4/4/2018	Wednesday	Team Lead & Assistant review of documentation in SharePoint
		Day 14	4/5/2018	Thursday	Team Lead & Assistant review of documentation in SharePoint
		Day 15	4/6/2018	Friday	
		Day 16	4/7/2018	Saturday	Weekend
		Day 17	4/8/2018	Sunday	Weekend
		Day 18	4/9/2018	Monday	Extension days for updates/revisions/additions to tool from units if needed
		Day 19	4/10/2018	Tuesday	Extension days for updates/revisions/additions to tool from units if needed
		Day 20	4/11/2018	Wednesday	Extension days for updates/revisions/additions to tool from units if needed
		Day 21	**4/12/2018**	**Thursday**	**Pre-audit meeting**
		Day 22	4/13/2018	Friday	Final revierw of pre-audit documentation by Team Lead & Assistant
		Day 23	4/14/2018	Saturday	Weekend
		Day 24	4/15/2018	Sunday	Weekend
		Day 25	**5/7/2018**	**Monday**	**Travel day**
		Day 26	5/8/2018	Tuesday	**Site 1 - Onsite review. Establish close out meeting time. Brief facility tour.**
		Day 27	5/9/2018	Wednesday	Site 1 - Onsite review / close out meeting.
		Day 28	5/10/2018	Thursday	Site 2- Onsite review / Establish close out meeting.
		Day 29	**5/11/2018**	**Friday**	**Site 2- Onsite review / close out meeting./Travel Day**
		Day 30	5/12/2018	Saturday	Weekend
		Day 31	5/13/2018	Sunday	Weekend
		Day 32	5/14/2018	Monday	
		Day 33	5/15/2018	Tuesday	Team Lead & Assistant review the report for completion**/Schedule HQ Post Audit Meeting /** Assign to Unit Chiefs for review via SharePoint
			5/16/2018	Wednesday	**Unit Chief review**
			5/17/2018	Thursday	**Unit Chief review**
			5/18/2018	Friday	**Unit Chief review**
			5/19/2018	Saturday	Weekend
			5/20/2018	Sunday	Weekend
			5/21/2018	Monday	Team Lead & Assistant review the report for completion and routes to **Leadership (DADs and AD)** via SharePoint.
			5/22/2018	Tuesday	**Leadership review (all DADs and AD)**
			5/23/2018	Wednesday	**Leadership review**
			5/24/2018	Thursday	**Leadership review**
			5/25/2018	Friday	No tasks
			5/26/2018	Saturday	Weekend
			5/27/2018	Sunday	Weekend
			5/28/2018	**Monday**	Team Lead & Assistant review the report for completion
			5/29/2018	Tuesday	Team Lead & Assistant review the report for completion
			5/30/2018	Wednesday	Team Lead & Assistant **review the report for completio**n
			5/31/2018	Thursday	
			6/1/2018	**Friday**	**Link to final report will be routed to the facility H.S.A., RHSA, and MQM Compliance Monitoring Specialist via SharePoint**
			6/2/2018	Saturday	
			6/3/2018	Sunday	
			6/4/2018	Monday	
			6/5/2018	Tuesday	
			6/6/2018	Wednesday	
			6/7/2018	Thursday	
			6/8/2018	Friday	
			6/9/2018	Saturday	
			6/10/2018	Sunday	
			6/11/2018	Monday	
			6/12/2018	Tuesday	

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	Jena
Start Date	2017-05-14
End Date	2017-05-19
Status	Report Complete
Corrective Action Required?	Yes
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	NaN
Specialist, MQMU	(b)(6); (b)(7)(C)

Headquarters Review

Chief, Health Operations Unit Review Status	Review Deferred (Team Lead Only)
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Deferred (Team Lead Only)
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Review Deferred (Team Lead Only)

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1162.00
MHU Beds	5.00
Daily Adult Male Population	978.00
Daily Adult Female Population	126.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	108.00
Comments	MHU has 6 beds but one was restricted by HQ

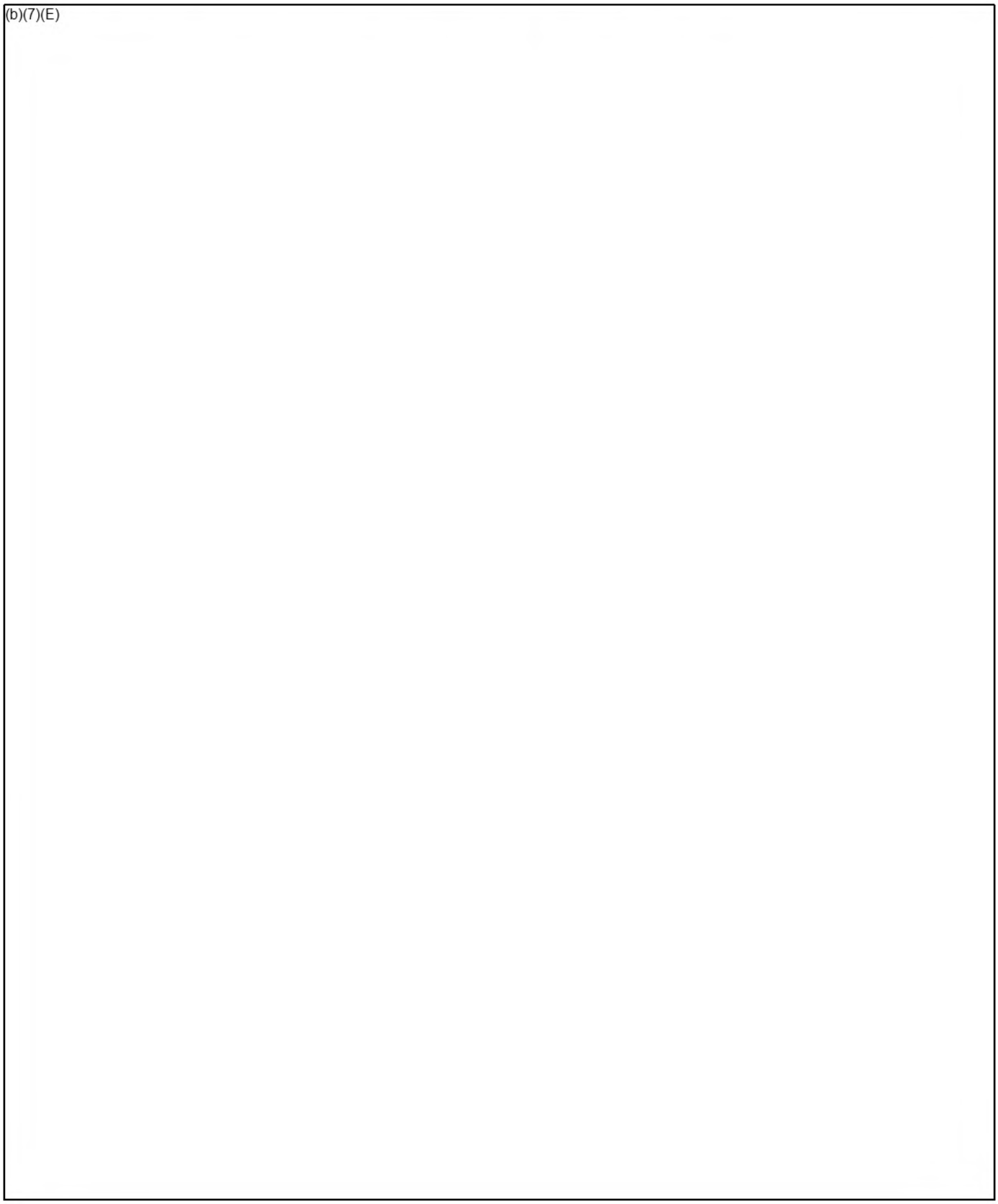
Average Number of Encounters (Past 3 Months)

Prescreenings	1532.00
Intake Screenings	1315.00
Physical Examinations	800.00
Vitals/Labs	40.00
Sick Call	480.00
Pros/Imm	17.00
Acute	110.00
Chronic	148.00
Mental Health	275.00
Dental	95.00
Emergent/Urgent	15.00
MHU	336.00
Segregation	324.00
Admin	183.00
Transfers	1199.00
Pill-Line Passes	2132.00
Prescriptions (Pill-line + KOP)	3080.00
Referrals/ER	32.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)



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Accreditation - Review Complete

Last ACA Accreditation	2014-11-17
Last ACA Findings	NO DATA
Last NCCHC Accreditation	2014-04-28
Last NCCHC Findings	Essential Standards Not in Compliance J-A-06 Continuous Quality Improvement Program J-G-04 Basic Mental Health Services Important Standard Not in Compliance J-D-05 Hospital and Specialty Care J-A-06 Continuous Quality Improvement Program (E). The comprehensive CQI program monitors major aspects of health care through a multidisciplinary committee that meets at least quarterly. The membership includes the HSA, CQI nurse, pharmacist, dentist, medical records clerk, and staff nurses as needed. An outcome CQI study examined glycosylated hemoglobin levels in diagnosed diabetic patients. Patients participated in education programs on disease process, diet, medication compliance, foot care and exercise. The majority of patients showed a decrease in their A 1 C levels over a three month period. The second study examined the prenatal care, specialized care and post-partum care of high risk pregnant inmates. Collaboration with community-based obstetricians resulted in newly implemented processes which improved the care delivered to all pregnant inmates. A process CQI study related to the influx of patients on medications that caused a delay to chronic care. Mid-level providers' schedules and locations were established. The nurse practitioners examined new intakes in the clinic room attached to housing. This move raised the threshold to 90%, as new intakes were examined in chronic care clinics within 72 hours and medications were started. A second process study examined the intake process because it was very time consuming and resulted in more than a 12 hour wait to complete. Schedules were modified, officers were educated and a new process was established. Now when the transportation bus arrives, the nurse goes on the bus to conduct a brief receiving screening to determine which new arrivals need to be seen as soon as possible. Those patients are then placed ahead of the others and go directly to the clinic for further evaluation. However, the responsible physician is not involved in the CQI program. He does not attend meetings or take part in the outcome or process studies, nor did he

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participate in the review of the CQI program. The standard is not met Corrective action is required for Compliance Indicator #2. The responsible physician should be involved in the CQI program, e.g., by identifying thresholds, interpreting data, and solving problems. Acceptable documentation includes a copy of CQI minutes demonstrating that the responsible physician is taking an active role in the CQI program. Documentation should also indicate how the responsible physician will be involved in the CQI program in the future. In order to receive accreditation, verification that this standard has been met is required. J-G-04 Basic Mental Health Services (E). On-site outpatient services includes the identification and referral of inmates with mental health needs, crisis intervention services, psychotropic medication management when indicated, short term individual counseling, and follow-up as needed. There are no organized psychosocial/psychoeducational programs. The standard is not met Corrective action is required for Compliance Indicator #2d. Regardless of a facility's type or size, basic on-site outpatient services should include individual counseling, group counseling, and psychosocial/psychoeducational programs. Acceptable documentation includes verification that psychosocial/psychoeducational programs will be available to inmates who need such services; the frequency and duration of such services should also be noted. In order to receive accreditation, verification that this standard has been met is required. J-D-05 Hospital and Specialty Care (I). Arrangements with a local hospital for inpatient medical and specialized medical outpatient care are by verbal agreement. Upon the patient's return from the hospital, the nurse calls the facility for treatment and follow up orders. The standard is not met. Corrective action is required for Compliance Indicators #1 and 2. Written agreements include a contract, letter of agreement, or memorandum of understanding between the facility and the hospital, clinic, or specialist for the care and treatment of patients. The standard intends that inmates have access to necessary hospitalization and specialty services and that the RHA anticipates and resolves problems in advance of the delivery of specialty care in order to ensure continuity. Agreements should require that the offsite facilities or health professionals give the inmate a summary of the treatment given and any follow-up instructions; this

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	information is to accompany the inmate on return to the facility. Acceptable documentation includes copies of written agreements with community hospitals and off-site specialists that include a provision for a summary of treatment and follow-up instructions to be returned with the inmate; an agreement should also clearly specify delivery services. Corrective action is required in order to meet this standard. NOTE: Facility submitted their response to the above findings, which NCCHC accepted. The facility received their initial NCCHC accreditation. Currently, IHSC is awaiting word from NCCHC on their next survey of the facility.
Last PBNDS Accreditation	2016-09-13
Last PBNDS Findings	No medical findings
Comments	NO DATA

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	83.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	3.00
Number of formal grievances.	83.00
Number of informal grievances.	0.00
Findings	Less than 3 percent not addressed timely. Not significant.
Deliverables	NO DATA

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Risk Management - Review Complete

Trends	NO DATA
Number of active RCAs/SOEs	1.00
Number of RCAs or SOEs completed during the last six (6) months.	1.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	Pending RCA related to mortality review with IIU. Pending further review.
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	1.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	10.00
Number of high risk medication refusals.	5.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	1.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	The nurse did an excellent job with the medication administration. She signed as she administered. The nurses are placing the refusal on the MAR however there is no documentation or explanation on the back of the MAR for the reason for refusal. There was only one encounter to the MLP for high risk medications.
Deliverables	The Nurse Manager will teach/retrain the nurses on the process of completing MAR refusal, including notification to the MLP. Explain High risk medication to the nurses. Ensure the process is completed appropriately.

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	Yes
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	Yes
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	No findings
Deliverables	NO DATA

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Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	N/A - See findings below.
Findings	Survey completed on May 17.
Deliverables	NO DATA

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	3.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	3.00
Number of psychotropic consent forms among the identified consent forms.	1.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	1.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	5 detainees were identified to be Psychotropic meds. 4 out of the 5 A numbers (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) did not have the psychotropic consent forms on file. Please assess on on-site observations
Deliverables	1st A# consent found. 2nd Consent pending scanning, 3rd ASF detainee, 4 th Incorrect A#.

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	22.00
Out of the transfers reviewed, how many had a positive chest X-ray?	2.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	0.00
Out of the transfers reviewed, how many have active TB?	0.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	14.00
Number of transfers with medication instructions clearly provided.	14.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) Transfer summary indicated TB screening modality as "CXR", but documentation reflected "PPD results" (b)(6); (b)(7)(C) Detainee with TB: Transfer summary indicated a positive CXR, but does not indicate negative labs or that a copy of the TB-CM was attached. TB-CM is still pending TB classification. Also transfer summary indicates that detainee was not being treated for Active TB, but TB medications are listed. (b)(6); (b)(7)(C) Transfer summary indicated "TB screening modality" as symptom screening, should reflect CXR as noted below on the transfer summary.
Deliverables	NO DATA

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Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	16.00
Number of prescreens that used a translator.	6.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	6.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	18.00
Number of prescreens with documentation completed in eCW prior to intake screening.	9.00
Findings	Nine (9) pre-screens not triaged according to pre-screen policy (no priority level listed) One pre-screen that did not use a translator, did not indicate the reason for not using a translator 16 pre-screens completed in eCW AFTER intake screening completed
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	5.00
Number of prescreen encounters observed that allowed for patient privacy.	5.00
If privacy was not provided, where was the prescreen performed?	NO DATA
Number of prescreen encounters that used language services.	0.00
Number of prescreen encounters completed within two hours of arrival.	5.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	5.00
Number of prescreen encounters prioritized.	5.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	5.00
Findings	All 5 prescreens were classified as LB-1 and prioritized for intake. Intakes were completed within 3 hours.
Deliverables	NO DATA

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	21.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	21.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	4.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	25.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	7.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	0.00
Number of intake screenings with pain scale greater than 0.	1.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	1.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	6.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	2.00
Number of intake screenings reviewed by an RN or above within 24 hours.	1.00
Findings	18 of out 25 Intake records reviewed, did not have TB documentation that was signed, dated and stamped by RN or above. During intake screening, detainee "states she has been sexually abused by partner. Does not want to speak to MH @ this time." However, there is no refusal form in the chart. Detainee responded affirmatively to having ever been physically or sexually abused; 7 years old; no mental health referral initiated 45-year old detainee indicates during Intake screening that they had a CVA 22 years ago. Intake screening coded as normal and scheduled for PE-S Intake screening conducted by LVN; RN documented their confirmatory sign-off, but not within 24 hours. Intake signed off on by LVN 4/1/17; Confirmatory sign-off by RN on 4/3/17 Of the 25 Intake charts reviewed, 4 were conducted by a LVN, requiring review by a RN or higher. Of those four charts, 1 was reviewed by a RN within 24 hours. The three others were reviewed by a RN, but not within 24 hours.
Deliverables	NO DATA

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Intake Screening Observations - Review Complete

Number of intake screenings observed.	4.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	4.00
Number of intake screening observations where a full set of vital signs were taken.	4.00
Number of intake screening observations that used language services.	2.00
Of the intake screening observations that used language services, how many were appropriately conducted?	2.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	4.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	0.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	The detainees were educated on access to care but were not educated on PE appointments and the grievance process.
Deliverables	The HSA is aware and the staff was educated on the entire process to include PE appointments and the grievance process.

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Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	9.00
Number of chronic care encounters with a PE-C completed within 48 hours.	18.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	25.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	24.00
Number of chronic care encounters with psychiatric medications.	4.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	4.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	4.00
Number of chronic care patients identified as stable.	10.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	15.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	6.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	19.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	25.00

Findings

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	1) 9 charts were appropriately referred based on category/severity but remainder did not require referrals 2) only 18 PE-C were completed within 48 hours 3) 1 particular patient's Cholesterol medication was not continued and was clinically indicated 4) Only 10 charts were identified as Stable/Good Control; poor documentation of the Status of Chronic Care Control (Stable/Fair/Good ect) Recommend use of Chronic Care Templates which includes the necessary status control 5) No chart was identified as Poor Control when 9 should have been identified as Poor Control with sooner chronic f/u (Less than 90 days) for overal better management 6) Only 19 charts had Global Alert completed/documented 7) Recommend
	(b)(5)
Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	5.00
Number of chronic care encounters observed that utilized language services.	5.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	5.00
Findings	No findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	25.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	25.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	0.00
Of the physical examinations with pain assessment, how many were addressed?	0.00
Number of physical examinations with clinically significant findings.	0.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	0.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	0.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	(6) PE-Complex not performed within 48 hours.
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	4.00
Number of physical examination encounters with a full set of vital signs taken.	4.00
Number of physical examination encounters observed that were completed within 14 days.	4.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	None of the detainees were offered chaperones but there was no examination of the breast or genitalia. There were no signs in the rooms that suggest that a chaperone could be provided.
Deliverables	The HSA made the appropriate signs and the staff were educated on the chaperone use process. Recommend that the PE template include the use of chaperones.

AMERICAN OVERSIGHT

Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	3.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	4.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	12.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	9.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	12.00
Number of sick call encounters where the reason is documented in the "Reason" field.	17.00
Number of sick call encounters where the reason for the visit was from an approved category.	25.00
Number of sick call encounters addressed by a nurse.	25.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	20.00
Findings	1) SOAP Format not completely/well documented (subjective and physical exam findings not complete/well documented or omitted) 2) Two occurrance where Inappropriate verbal order for antibiotic prescription medication given from provider to nurse without face to face documentation/evalutation by the provider 3) Remind to use nursing diagnosis
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	No - See findings below.
Findings	All the detainees in Segregation were seen. The detainees sign up for sick but they are consistently not seen on the day they sign up. The wait varies and is between 2-7 days. The log is not completed properly.
Deliverables	(b)(5)

AMERICAN OVERSIGHT

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	3.00
Number of MHU 23 hour observation records with discharge encounters.	3.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	3.00
Number of MHU 23 hour observation records with telephone order admission.	3.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	3.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	The staff training needs to occur to begin placing "Observation" under reason.
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	N/A - See findings below.
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	0.00
Number of MHU full admission records reviewed.	20.00
Number of MHU full admission records with admission encounters.	20.00
Number of MHU full admission records with discharge encounters.	16.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	20.00
Number of MHU full admission records with no PE within the past year.	0.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	0.00
Number of MHU full admission records with acuity level assigned.	19.00
Number of MHU full admission records with all medications placed on pill line.	20.00
Number of MHU full admission records with 24 hour chart reviews everyday.	20.00
Number of MHU full admission records for patients in segregation for medical overflow.	0.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0.00
Number of MHU full admission records with a nursing care plan.	20.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	20.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	20.00

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Number of MHU full admission records with mental health diagnoses.	2.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	2.00
Number of MHU full admission records without mental health diagnoses.	18.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00
Findings	(1) chart without an observation level (4) charts without discharge encounters
Deliverables	NO DATA

AMERICAN OVERSIGHT

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	1.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	1.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	1.00
Number of suicide watch records where the need for finger foos was annotated.	1.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	1.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	1.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	1.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	1.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	1.00
Findings	(b)(6); (b)(7)(C) This reviewer only found one chart in the last year.
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	There were no detainees on suicidal watch during this visit.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Hunger Strike - Review Complete

Number of hunger strike records reviewed.	3.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	3.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	3.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	3.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	3.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	3.00
Number of hunger strike records with special needs.	0.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	0.00
Findings	Inconsistent charting of orthostatic vital signs. No special needs forms documented. Recommend review of the HS policy, review of how to chart orthostatic vital signs to include qualifiers for the HR and BP (i.e. sitting/standing/lying BPs and HRs can be qualified in eCW), recommed review of how to chart SNFs
Deliverables	NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	7.00
Number of segregation records that indicate the patient was medically cleared for segregation.	7.00
Number of segregation records where daily segregation rounds by nursing are documented.	7.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	7.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	0.00
Number of segregation records where the patient was seen weekly by mental health.	7.00
Findings	No findings.
Deliverables	NO DATA

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	0.00
Number of after hours medication records with the patient's identification number documented.	0.00
Number of after hours medication records with medication order(s) documented in eCW.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	0.00
Does the pharmacy have a reconciliation process?	NO DATA
Does the pharmacy follow the reconciliation process?	NO DATA
Findings	NO DATA
Deliverables	NO DATA

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No - See findings below.
Are after hours medication orders documented as dispensed in eCW?	No - See findings below.
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	No - See findings below.
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	The medications were up to date with labelling however when they were retrieved from the cabinet the slips were not completed in its entirety. The A numbers or other identifiers were not utilized for removal therefore we could not confirm the documentation in eCW.
Deliverables	The HSA created new sheets with all the required information (A#, Last name, first name) for the retrieval process including the providers information. The staff was educated on the process. This was implemented prior to our departure.

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Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	22.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	24.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	24.00
Reasons for why a translator was not used.	In 5 out of 25 charts, the detainee's primary language documented on Intake was Spanish, but the provider/nurse documented that the detainee spoke English fluently in the encounters reviewed (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) In 3 out of 25 charts, the detainee was reported to speak English, but the language was not docmented in the encounter note. However, the provider/nurse did document that the detainee spoke English fluently to satisfy the question "reason no interpreter was used." (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) One chart had an interpreter number documented as "000." This is likely not correct as interpreter numbers documented in other charts are six digits (b)(6); (b)(7)(C) Overall, this reviewer recommends: (1) Ensuring that the detainee's primary language is clarified, (2) Using an interpreter when the detainee's primary language is not English or if the provider/nurse does not speak the detainee's primary language, and (3) Documenting the language used in encounters
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	GEO has the TTY line available for the detainees.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	Further clarification is needed in items 3 and 11- calibration of testing devices to ensure accuracy and saftey checks for medical and diagnostic equipment.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	4.00
Number of refridgerator temperature logs that are up to date.	4.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	No findings
Deliverables	NO DATA

AMERICAN OVERSIGHT

Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	8.00
Number of daily assignment sheets completed and archived .	8.00
Number of daily assignment sheets with one emergency team identified per shift.	8.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	8.00
Number of daily assignment sheets with clinic inspection completed and signed.	8.00
Are detainee referrals documented?	Yes
Findings	NO DATA
Deliverables	NO DATA

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	N/A - See findings below.
Findings	No written changes were observed.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	No findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	1.00
Number of federal civil service employee personnel files reviewed.	1.00
Number of contractor personnel files reviewed.	4.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	Yes
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	4.00
Of the personnel file records for priveleged staff, how many are current?	4.00
Number of personnel files with current and signed Health and Ability form.	6.00
Number of personnel files with a signed statement of confidentiality (one time).	6.00
Number of personnel files with a signed statement of risks and responsibility (one time).	6.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	6.00
Number of personnel files with a signed release of information form (one time).	6.00
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	1.00
Number of federal civil service employee credentialing files reviewed.	1.00
Number of contractor credentialing files reviewed.	7.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	9.00
Number of credentialing files with current, valid, and unrestricted license.	9.00
Number of credentialing files with license primary source verification.	9.00
Number of credentialing files with documentation of primary education.	9.00
Number of credentialing files with education primary source verification.	9.00
Number of credentialing files reviewed for physicians or psychiatrists.	1.00
Number of physician or psychiatrist credentialing files with documentation of residency.	0.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	1.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	0.00
Number of credentialing files with a curriculum vitae or resume.	9.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	0.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	3.00
Number of credentialing files with scope of practice.	4.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	3.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	9.00
Number of peer reviews reviewed.	2.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	2.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	NO DATA
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	5.00
Number of employee health files with current TB (PPD or CXR) documentation.	5.00
Number of employee health files with current Hepatitis B vaccination or declination form.	5.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	0.00
Number of employee health files with current respirator medical clearance.	5.00
Number of employee health files with current respirator fit test.	5.00
Number of employee health files with emergency contacts.	5.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	N/A - See findings below.
Findings	Ishihara Color test not found in records. HSA/AHSA was made aware and will implement immediately.
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	4.00
Number of training folders with HSD-500.	4.00
Number of training folders with a signed position description.	4.00
Number of registered nurse training folders reviewed.	2.00
Number of registered nurse training folders with RN Physical Exam Training.	2.00
Number of training folders with continuing medical education credits.	2.00
Number of training folders with BLS for health care providers or CPR and AED certification.	4.00
Number of radiation safetoy officer training folders with radiation safety training.	3.00
Findings	NO DATA
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	N/A - See findings below.
Is hand hygiene monitoring conducted and documented?	Yes
Findings	The facility utilizes the IHSC hygiene monitoring tool.
Deliverables	NO DATA

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	No findings
Deliverables	NO DATA

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
Report generated: undefined

Assessment Information - Report Complete

Facility	Jena
Site visit start date	2019-03-01
Site visit end date	2019-06-14
Fiscal Year	FY2019
Fiscal Quarter	Q2
Post-audit corrective action identified	No
Immediate corrective action identified	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Pending Report Completion
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Deferred (Team Lead Only)
Chief of Staff Review Status	Review Deferred (Team Lead Only)
AD, IHSC Review Status	Review Deferred (Team Lead Only)

Facility Information - Review Complete

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Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1300
MHU Beds	6
Daily Adult Male Population	985
Daily Adult Female Population	157
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	33
Facility Information Comments	No data reported

Average Number of Encounters (Past 3 Months)

Prescreenings	932
Intake Screenings	855
Physical Examinations	635
Vitals/Labs	484
Sick Call	677
Pros/Imm	132
Acute	196
Chronic	185
Mental Health	277
Dental	110
Emergent/Urgent	16
MHU	491
Segregation	608
Admin	308
Transfers	930
Pill-Line Passes	1484
Prescriptions (Pill-line + KOP)	5703
Referrals/ER	77

Accreditation - Review Complete

Last ACA Accreditation	2017-11-13T05:00:00Z
Last ACA Findings	100% compliance
Last NCCHC Accreditation	2017-11-01T04:00:00Z

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Last NCCHC Findings	1."TRIAD" health care statistics were not documented at Triad meeting. 2. An emergency plan that addresses the requirements of the standard, and has been approved by the facility administrator as well as the responsible health authority, is required for full compliance. 3. Insufficent documentation that the intake screening was reviewed. 4. Sick call logs dates could not be read
Last PBNDS Accreditation	2018-09-25T04:00:00Z
Last PBNDS Findings	100% compliance
Accreditation Comments	none

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	25
Of the after hours med log records reviewed, how many records documented the patient's identification number?	25
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	25
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	23
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	2 records generated by a nurse as a telephone order were not signed by a provider within 24 hours of return for next work shift
After Hours Medication Chart Review Deliverables	2 records generated by a nurse as a telephone order were not signed by a provider within 24 hours of return for next work shift; this one provider has been reeducated on the importance of this process

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	No
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
	Yes

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Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	
After Hours Medication Encounters Findings	Is the after hours verbal medication order entered into eCW by the prescriber upon return to Duty: Telephone Orders is done by nurse the APP comes in and does not complete the order in eCW.
After Hours Medication Encounters Deliverables	Is the after hours verbal medication order entered into eCW by the prescriber upon return to Duty: Telephone Orders is done by nurse the APP comes in and does not complete the order in eCW. The new Smart system will assist with this issue; along with enforcement of proper process to medical staff

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	25
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	24
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	24
Of the chronic care records reviewed, how many detainees had psychiatric medications?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	0
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	1
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	25
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	0
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	0
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	2
Chronic Care Records Findings	Detainees that were on psychiatric medication length of stay was less then 90 days

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Chronic Care Records Deliverables	none

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	10
Of chronic care encounters observed, how many were considered stable patients?	9
Of the stable patients observed, how many were completed within the appropriate timeframe?	9
Of chronic care encounters observed, how many were considered unstable patients?	1
Of the unstable patients observed, how many were completed within the appropriate timeframe?	1
Of the chronic care encounters observed, how many had a treatment plan?	10
Chronic Care Encounters Findings	None
Chronic Care Encounters Deliverables	none

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	15
Of the consent forms reviewed, how many were general consent forms?	15
Of the general consent forms reviewed, how many were complete?	2
Of the consent forms reviewed, how many were dental consent forms?	0
Of the dental consent forms reviewed, how many were complete?	0
Of the consent forms reviewed, how many were psychotropic consent forms?	0
Of the psychotropic consent forms reviewed, how many were complete?	0
Consent Forms Findings	none
Consent Forms Deliverables	none

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	10
	10

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Of the daily assignment sheets reviewed, how many were archived appropriately?	
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	10
Daily Assignment Sheets Findings	The assignments are given at shift reprot daily and are written on a dry erase board in the nurses station. The reviewer noted this information given over a 10 day period.
Daily Assignment Sheets Deliverables	none

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	none
Diagnostic Services Deliverables	none

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	Yes

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Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	none
Emergency Preparedness and Response Deliverables	none

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	Yes
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	none
Environmental Health Deliverables	none

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	2
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	2
Number of informal grievances.	0
Grievances Findings	none
Grievances Deliverables	none

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Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	0
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	0
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	0
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	0
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	0
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	0
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	0
Hunger Strike Records Findings	no patients identified during the evaluation period
Hunger Strike Records Deliverables	n/a

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	0
Of the patients on a hunger strike, how many were offered meals?	0
Of the patients on a hunger strike who were offered food, how much food was offered?	No hunger strikes for the evaluation period.
Of the food offered, how much of the food was eaten?	No data reported
Of the patients on a hunger strike, how many had special needs?	0

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Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	no hunger strikes for the evaluation period
Hunger Strike Encounters Deliverables	n/a

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	none
Infectious Disease Prevention Deliverables	none

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	15
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	15
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	10
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	1
Of the records with a pain scale greater than 0, how many were assessed?	1
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	6
Of the intake records with clinically significant findings, how many were referred appropriately?	6
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	0

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Intake Screen Records Findings	5 recorded needed to be reviewed by an RN however this did not occur in the 24 hour timeframe
Intake Screen Records Deliverables	The nurse manager discussed sign off with LPN's during evening and morining report.

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	10
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	10
Of the intake screen encounters observed, how many included a full set of vital signs?	10
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	10
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	10
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	10
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	0
Intake Screen Encounters Findings	none
Intake Screen Encounters Deliverables	none

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	25
Of the language access records reviewed, how many did not use a translator?	8
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	8
Language Access Records Findings	none
Language Access Records Deliverables	none

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Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	No
Language Access Encounter Findings	We have hearing amplifiers but nothing for someone that is completly deaf
Language Access Encounter Deliverables	ICE leadership is aware

Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	5
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	3
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	5
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	No
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	No
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	No
Log Books Findings	Sometimes log signatures were missing and whole counts were missing.
Log Books Deliverables	(b)(5)

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	10

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Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	10
Of the medication administrations observed, how many mouth checks were conducted?	8
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	10
How many MAR entries were observed?	10
Of the MAR entries observed, how many were complete?	0
Of the MAR entries observed, how many medication refusals were documented?	0
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	0
Of the identified medication refusals, how many were high-risk medications?	0
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	0
Medication Administration Findings	Errors have been noted on EMARS. Medications were giving past expiration dates.
Medication Administration Deliverables	Work closely with sMARt Team regarding any potential discrepancies .

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	2
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	ICE/HSA meetings are conducted on a weekly bases
Meetings Deliverables	none

MHU Full Admission Chart Review - Review Complete

How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	19

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Of the MHU full admission records reviewed, how many had a documented PE within the past year?	22
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	2
Of the MHU full admission records reviewed, how many had a nursing care plan?	19
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	21
Of the MHU full admission records reviewed, how many had patient education provided daily?	21
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	4
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	3
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	21
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	22
MHU Full Admission Records Findings	1. Of the 25 MHU full admission records reviewed, 6 did not have admission orders documented via the eCW MHU admission template. 2. Two detainees did not have a PE documented within the past year due to being new to IHSC system and came to MHU during intake. One detainee was in MHU for one day then transfered . 3. Of the 25 MHU full admission charts reviewed, nursing care plans were completed per policy, however, there was no documentation indicating the care plan was reviewed/updated daily on 4 of the MHU patients.
MHU Full Admission Records Deliverables	1. Providers will be instructed and educated on utilizing the MHU admission template for all MHU admissions. 2. Providers were educated on policy and need for PEC to be completed within 24 hours of MHU admission. 3. Nursing staff were educated during staff meetings that all MHU full admission require a nursing care plan and that it must be reviewed and/or updated daily.

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	5
How many patients are in the MHU full admission at the time of observation?	6

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How many MHU full admission patients have a 24-hour chart review everyday?	23
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	25
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	25
MHU Full Admission Encounters Findings	Some MHU templates were completed during a PEC. At times, the MD does not list follow up time frame. Mental Health team is thorough and follow up well. Two detainees were in MHU less than 24 hours.
MHU Full Admission Encounters Deliverables	Medical staff were instructed at time of observation as well as during staff meetings that 24 hour chart reviews are required daily.

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	12
Of personnel and credentialing files reviewed, how many were PHS officers?	2
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	2
Of personnel and credentialing files reviewed, how many were federal civil service employees?	1
Of personnel and credentialing files reviewed, how many were contractors?	9
Of personnel and credentialing files reviewed, how many records are for privileged staff?	5
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	5
Of the LIP staff records reviewed, how many had personnel files records current?	5
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	5
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	12
	12

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Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	12
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	12
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	10
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	12
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	5
Of the staff records reviewed, how many had scope of practice documentation if applicable?	7
Personnel and Credentialing Files Findings	Verification of diploma is needed on one contractor. STGi has been notified and is currently working on getting verification which will be sent over as soon as they receive it. Annual Licensure verification on one contractor is in the process of being verified per STGi. Verification documentation will be sent over as soon as it is processed. There are fees associated with both verifications; therefore, STGi is responsible for payment.
Personnel and Credentialing Files Deliverables	Currently at 90% for a goal of 100%. We are working with the contractor to obtain 100% verification. UPDATE: Spoke with Site HSA on 11/19/2019. All files have been updated and verification has been received for all providers. Issue has been resolved.

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	15
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	15
Of the physical exam charts reviewed, how many were for juveniles?	0

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Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	13
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	3
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	7
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	11
Of the physical exam charts reviewed, how many were for adult females?	5
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	5
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	5
Physical Exam Records Findings	We have no juveniles; Paps offered, none were indicated 13 - PE-Ss completed within 14 days the others were n/a as they were PE-C per policy. 12 - PE-Cs completed within 14 days the others were n/a as they were PE-S per policy. 5 of the PE-Cs and 2 of the PE-Ss were not reviewed in the proper time frame due to limited staffing availabililty.
Physical Exam Records Deliverables	Working close together with Clinical Services to ensure there is overlap of coverage. During periods of limited staffing.

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	10
Of the physical exam encounters observed, how many included a full set of vital signs?	10
Of the physical exam encounters observed, how many were completed within the specified timeframe?	10
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	2
Of the physical exam encounters observed, how many had an abnormal vital sign?	2
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	2

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Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	10
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	10
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	0
Physical Exam Encounters Findings	None of the PEs required next level of care. Abnormal VS were addressed and refered to a higher lever of care.
Physical Exam Encounters Deliverables	none

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	10
Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	Yes
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	10
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	10
Prescreen Encounters Findings	english was checked on all prescreens when some only spoke spanish.
Prescreen Encounters Deliverables	Remind staff during shift report and monthly Staff Meetings of the importance of individualizing Templates. Per RHSA Sawyers, site to discuss this with the RHSA and RNM during biweekly triad meetings.

Risk Management - Review Complete

Trends	No data reported
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	0
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	2
List all corrective actions identified in the preceding field and note their status and due dates.	No data reported
Risk Management Findings	No data reported
Risk Management Deliverables	No data reported

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Schedules - Review Complete

How many schedules were reviewed?	2
Of the schedules reviewed, how many had a legend to explain codes?	2
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	2
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	2
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	2
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	none
Schedules Deliverables	none

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	26
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	15
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	26
Of the segregation records reviewed, how many offered the patient daily sick-call services?	26
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	26
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	13
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	12
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	12
Segregation Records Findings	Staff indicate the the patient is cleared for SEg on a GEO form. The Form is given to GEO.
Segregation Records Deliverables	Deliverables discussed with RHSA (b)(5); (b)(6); (b)(7)(C) (b)(5)

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Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	0
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	none
Segregation Encounters Deliverables	none

Shift Report and Time Cards - Review Complete

Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	Yes
Shift Report and Time Cards Findings	none
Shift Report and Time Cards Deliverables	none

Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	0
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	0
Of the sick call records reviewed, how many included a full set of vital signs?	25
Of the sick call records reviewed, how many had a pain scale greater than 0?	12
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	12
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	23
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	25

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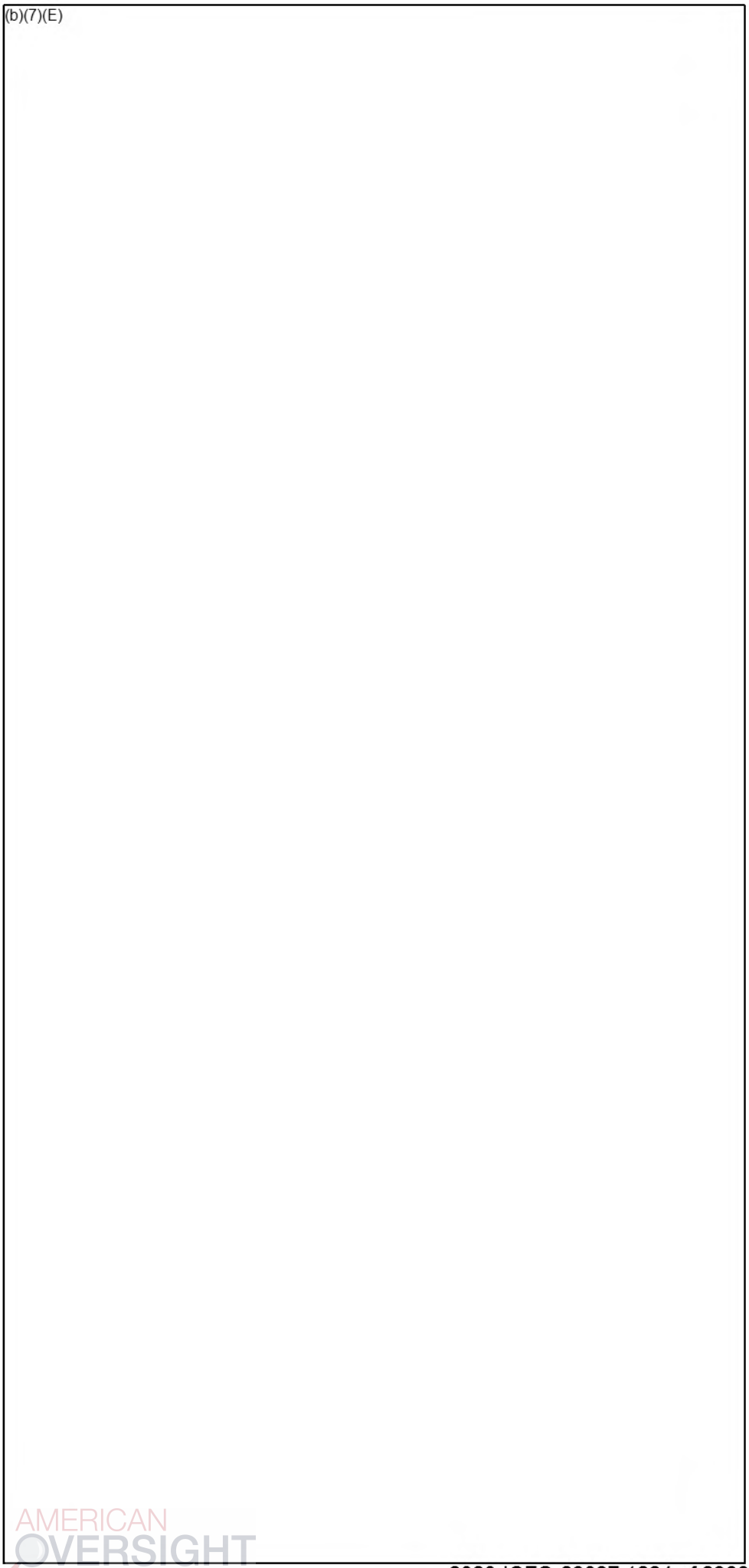
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	25
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	Yes
Sick Call Records Findings	none
Sick Call Records Deliverables	none

Staffing Information - Review Complete

(b)(7)(E)

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(b)(7)(E)



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(b)(7)(E)

(b)(7)(E)

Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed?	1
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	1
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	1
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	1
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	1
Of the suicide watch records, how many had a patient released from suicide watch?	1
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	1
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	1
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	1
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	1
Suicide Watch Pre-Audit Findings	Only one patient during the evaluation period
Suicide Watch Pre-Audit Deliverables	none

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	1
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	0
	0

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Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	1
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	1
Suicide Watch Encounters Findings	Patient refused to have vitals taken
Suicide Watch Encounters Deliverables	Ensure custody is performing 15min staggered interval checks despite the detainee refusing medical care. Provide follow up to RHSA and RNM during Local Triads.

Training - Review Complete

How many training folders were reviewed?	12
Of the training folders reviewed, how many had a HSD-500?	12
Of the training folders reviewed, how many had a signed position description ?	12
Of the training folders reviewed, how many were registered nurse training folders?	5
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	5
Of the training folders reviewed, how many had continuing medical education credits documented?	6
Training Findings	2 files were LPN - Continuing education does not apply to them 3 of the files had documentation of CEs but not for 2018-19 Employees have been contacted to submit documentation of CEs
Training Deliverables	LPN/LVN are not required to do CE in the state of LA.

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	25
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	25

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Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	0
Transfers Findings	none
Transfers Deliverables	none
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	25
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	5

Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	11
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	11
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	0
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	11
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	12
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	Hep B - Series has been started but is not complete and no declination on file
Workforce Health Files Deliverables	none

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	Pearsall
Start Date	2017-04-09
End Date	2017-04-14
Status	Report Complete
Corrective Action Required?	No
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Deferred (Team Lead Only)
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Review Complete

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1895.00
MHU Beds	20.00
Daily Adult Male Population	1600.00
Daily Adult Female Population	200.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	30.00
Comments	NO DATA

Average Number of Encounters (Past 3 Months)

Prescreenings	1006.00
Intake Screenings	1006.00
Physical Examinations	833.00
Vitals/Labs	144.00
Sick Call	1632.00
Pros/Imm	1263.00
Acute	158.00
Chronic	110.00
Mental Health	335.00
Dental	152.00
Emergent/Urgent	436.00
MHU	152.00
Segregation	360.00
Admin	55.00
Transfers	1188.00
Pill-Line Passes	6802.00
Prescriptions (Pill-line + KOP)	1516.00
Referrals/ER	26.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)

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Accreditation - Review Complete

Last ACA Accreditation	2016-12-05
Last ACA Findings	NO DATA
Last NCCHC Accreditation	2015-03-31
Last NCCHC Findings	This facility's initial NCCHC survey was conducted March 31-April 1, 2015. Facility found compliant on 100% of all applicable essential standards, and all applicable important standards.
Last PBNDS Accreditation	2016-03-22
Last PBNDS Findings	No medical findings. Next PBNDS audit is 3-28-17
Comments	NO DATA

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	14.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	14.00
Number of informal grievances.	0.00
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Risk Management - Review Complete

Trends	Facility reported a total of 133 incident reports during 1st quarter of FY 17. No identifiable trends noted.
Number of active RCAs/SOEs	0.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	None
Findings	None
Deliverables	None

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	No - See findings below.
Number of all medication refusals documented on the MAR.	7.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	- Mouth checks are being performed on every detainee; however, checks may be assisted with the use of pen lights to ensure no cheeking of medications. -(b)(5) (b)(5)
Deliverables	NO DATA

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	Yes
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	No - See findings below.
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	Available via SharePoint. Drills consist of nursing staff and providers. Mortality sequence of events did not occur within 24 hours however facility was provided with a different submission deadline. Best Practice-HSA advocated to have all staff equiped with radios. Emergecy calls are heard immediately due to all staff having access to this.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	N/A
Deliverables	NO DATA

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	3.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	3.00
Number of psychotropic consent forms among the identified consent forms.	5.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	5.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	2 detainees Identified had dental visits within the review period and they both had dental consent forms. 5 detainees were identified on psychotropic meds, All 5 completed psychotropic consent forms.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	24.00
Out of the transfers reviewed, how many had a positive chest X-ray?	5.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	4.00
Out of the transfers reviewed, how many have active TB?	5.00
Out of the transfers with active TB, how many are not being treated for TB?	5.00
Number of transfers with chronic medical conditions or lack thereof annotated.	5.00
Number of transfers with medication instructions clearly provided.	5.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) Transfer summary indicates that detainee is not being treated for active TB disease, but medications are listed on transfer summary. TFX_Num_Active TB - transfer summary does not distinquish between Active TB confirmation and TB suspect, only non-infectiousness.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	22.00
Number of prescreens that used a translator.	14.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	14.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	11.00
Number of prescreens with documentation completed in eCW prior to intake screening.	4.00
Findings	NO DATA
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	3.00
Number of prescreen encounters observed that allowed for patient privacy.	3.00
If privacy was not provided, where was the prescreen performed?	Not applicable
Number of prescreen encounters that used language services.	0.00
Number of prescreen encounters completed within two hours of arrival.	3.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	3.00
Number of prescreen encounters prioritized.	3.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	1.00
Findings	Observed three pre-screenings. All were prioritized in referred in a timely manner.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	6.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	6.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	18.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	23.00
Of the intake screening records, how many were TB negative?	23.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	7.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	0.00
Number of intake screenings with pain scale greater than 0.	1.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	0.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	8.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	4.00
Number of intake screenings reviewed by an RN or above within 24 hours.	16.00
Findings	NO DATA
Deliverables	NO DATA

Intake Screening Observations - Review Complete

Number of intake screenings observed.	3.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	3.00
Number of intake screening observations where a full set of vital signs were taken.	3.00
Number of intake screening observations that used language services.	3.00
Of the intake screening observations that used language services, how many were appropriately conducted?	3.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	3.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	3.00
Number of intake screening observations with security advice of special needs and housing disposition.	3.00
Of the intake screening observations with security advice, how many contained clear communications?	3.00
Findings	Process is well structured for intake.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	23.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	24.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	20.00
Number of chronic care encounters with psychiatric medications.	9.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	9.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	9.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	0.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	17.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	19.00

Findings

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	(4) charts did not continue medications appropriately (2) charts did not hve PE-C completed in 48 hours (8) charts did not have global alert (6) charts did not have baseline medical data
Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	5.00
Number of chronic care encounters observed that utilized language services.	3.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	5.00
Findings	No descrepancies noted (b)(5) (b)(5)
Deliverables	NO DATA

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	4.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	4.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	6.00
Of the physical examinations with pain assessment, how many were addressed?	5.00
Number of physical examinations with clinically significant findings.	15.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	15.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	25.00
Number of physical examinations for females.	2.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	2.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	(1) chart did not address pain
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	5.00
Number of physical examination encounters with a full set of vital signs taken.	5.00
Number of physical examination encounters observed that were completed within 14 days.	5.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	- All five exams had a female staff member examine a male detainee; however, none of the exams included an examination of the genitalia and or rectal area. The chest was examined for heart sounds and lung sounds. (b)(5) (b)(5)
Deliverables	NO DATA

AMERICAN OVERSIGHT

Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	8.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	3.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	21.00
Number of sick call encounters with a pain scale greater than 0.	17.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	14.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	17.00
Number of sick call encounters where the reason is documented in the "Reason" field.	25.00
Number of sick call encounters where the reason for the visit was from an approved category.	22.00
Number of sick call encounters addressed by a nurse.	22.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	22.00

Findings (b)(5)

Deliverables NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	Yes
Findings	New implenentation of a sick call process has been working well for facility. RN's conducting sick call provide a one time dose. Other issues or concerns are seen by Providers. Training was conducted with all staff during on-site assessment.
Deliverables	NO DATA

AMERICAN OVERSIGHT

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	10.00
Number of MHU 23 hour observation records with discharge encounters.	10.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	10.00
Number of MHU 23 hour observation records with telephone order admission.	1.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	1.00
Number of MHU 23 hour observation records labeled "Observation".	4.00
Findings	Very inconsistent admission notes by providers, inconsistent labeling of MHU Observation admission (usually able to find this within the note but not clearly labeled, over 23 hour admit not converted over to MHU full admission
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	N/A - See findings below.
Number of nurses in the MHU at time of observation.	1.00
Number of patients in the MHU at time of observation.	1.00
Number of MHU full admission records reviewed.	17.00
Number of MHU full admission records with admission encounters.	16.00
Number of MHU full admission records with discharge encounters.	14.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	17.00
Number of MHU full admission records with no PE within the past year.	0.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	0.00
Number of MHU full admission records with acuity level assigned.	16.00
Number of MHU full admission records with all medications placed on pill line.	17.00
Number of MHU full admission records with 24 hour chart reviews everyday.	17.00
Number of MHU full admission records for patients in segregation for medical overflow.	1.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	1.00
Number of MHU full admission records with a nursing care plan.	17.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	17.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	17.00

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Number of MHU full admission records with mental health diagnoses.	4.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	4.00
Number of MHU full admission records without mental health diagnoses.	13.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	13.00
Findings	(3) charts did not have discharge instruction (1) chart did not have admission (1) chart did not list acuity level
Deliverables	NO DATA

AMERICAN OVERSIGHT

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	9.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	9.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	8.00
Number of suicide watch records where the need for finger foos was annotated.	8.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	9.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	8.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	8.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	8.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	6.00
Findings	This reviwer found only 9 applicable charts. Finger foods/SW smock/daily MH rounds/etc. noted in 89 out of 10 charts. This is not a negative finding because one detainee was immediately referred to the ER for follow up. Special needs forms documenting finger foods and SW smock were not scanned into eCW in two charts (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Although, the need for finger foods and SW smock was indicated in the eCW note. Recommend using SNF consistently. (b)(5) (b)(5)
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	No detainees on suicide watch during site assessment.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Hunger Strike - Review Complete

Number of hunger strike records reviewed.	2.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	2.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	2.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	0.00
Number of hunger strike records with special needs.	2.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	2.00
Findings	Unable to locate I&O flowsheets, orthostatic v/s not found or inconsistent, no CD or MD discharge from HS notes
Deliverables	NO DATA

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Segregation - Review Complete

Number of segregation records reviewed.	10.00
Number of segregation records that indicate the patient was medically cleared for segregation.	9.00
Number of segregation records where daily segregation rounds by nursing are documented.	10.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	10.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	10.00
Number of segregation records where the patient was seen weekly by mental health.	10.00
Findings	(1) chart did not have encounter to medically clear detainee.
Deliverables	NO DATA

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	10.00
Number of after hours medication records with the patient's identification number documented.	10.00
Number of after hours medication records with medication order(s) documented in eCW.	10.00
Number of after hours medication records that were generated by a nurse as a telephone order.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	0.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	Providers enter the telephone encounter as they have taken the medication.
Deliverables	NO DATA

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	Pharm staff conduct daily checks.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	24.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	24.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	9.00
Reasons for why a translator was not used.	(b)(6); (b)(7)(C) No interpreter used, detainee deaf/mute-nurse documented that the detainee could "read lips and communicates with gestures;" (b)(6); (b)(7)(C) -Detainee reported Portuguese as his language, nurse documented "DETAINEE'S NATIVE LANGUAGE IS PORTUGUESE, BUT ABLE TO COMMUNICATE IN SPANISH;" (b)(6); (b)(7)(C) Detainee reported Spanish as his language on intake, nurse documented "Detainee speaks English fluently; (b)(6); (b)(7)(C) Hindi documented on Intake, but nurse used a Punjabi interpreter (this may not be a finding as Hindi/Punjabi may be interchangable, this reveiwer can not verify this though); (b)(6); (b)(7)(C) Spanish documented on Intake, but nurse documented that the detainee spoke English fluently; (b)(6); (b)(7)(C) Detainee speaks Somali. Nurse documented that he spoke the detainee's native language. Can not verify that nurse speaks Somali, but it is likely a negative finding.
Findings	NO DATA
Deliverables	NO DATA

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Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	NO DATA
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	NO DATA
Findings	- Exam rooms and intake rooms had the "I Speak signs posted."
Deliverables	NO DATA

AMERICAN OVERSIGHT

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	4.00
Number of refridgerator temperature logs that are up to date.	4.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	-no logs to show monthly inventories were performed on emergency equipment as well as inventory when seals are broken. - Why tool logs for thermometers and stethescopes? Are there tool logs for hemostatss, scissors, etc. - identified 2 containers of vacucontainers that were expired. Staff removed them from use and disposed of htem.
Deliverables	-Refrigerator temeprature not recorded on weekends in pharmacya nd dental due to no staff in those areas on weekends and the thermometer used does not record multiple days. A model number for an optional thermater was provided to the AHSA.

(b)(5)

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Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	10.00
Number of daily assignment sheets completed and archived .	0.00
Number of daily assignment sheets with one emergency team identified per shift.	10.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	8.00
Number of daily assignment sheets with clinic inspection completed and signed.	8.00
Are detainee referrals documented?	Yes
Findings	(b)(5)
Deliverables	NO DATA

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	No issues
Deliverables	NO DATA

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	Was able to witness an ICE meeting with all stakeholders.
Deliverables	NO DATA

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Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	6.00
Number of federal civil service employee personnel files reviewed.	1.00
Number of contractor personnel files reviewed.	7.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	NO DATA
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	3.00
Of the personnel file records for priveleged staff, how many are current?	3.00
Number of personnel files with current and signed Health and Ability form.	14.00
Number of personnel files with a signed statement of confidentiality (one time).	14.00
Number of personnel files with a signed statement of risks and responsibility (one time).	0.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	14.00
Number of personnel files with a signed release of information form (one time).	14.00
Findings	(b)(5)
Deliverables	NO DATA

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Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	6.00
Number of federal civil service employee credentialing files reviewed.	1.00
Number of contractor credentialing files reviewed.	7.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	14.00
Number of credentialing files with current, valid, and unrestricted license.	14.00
Number of credentialing files with license primary source verification.	14.00
Number of credentialing files with documentation of primary education.	14.00
Number of credentialing files with education primary source verification.	14.00
Number of credentialing files reviewed for physicians or psychiatrists.	3.00
Number of physician or psychiatrist credentialing files with documentation of residency.	3.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	2.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	2.00
Number of credentialing files with a curriculum vitae or resume.	14.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	0.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	7.00
Number of credentialing files with scope of practice.	14.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	6.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	14.00
Number of peer reviews reviewed.	2.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	0.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	Files kept organized. COER evaluations not included. (b)(5)
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	14.00
Number of employee health files with current TB (PPD or CXR) documentation.	14.00
Number of employee health files with current Hepatitis B vaccination or declination form.	14.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	14.00
Number of employee health files with current respirator medical clearance.	14.00
Number of employee health files with current respirator fit test.	14.00
Number of employee health files with emergency contacts.	14.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	14.00
Number of training folders with HSD-500.	14.00
Number of training folders with a signed position description.	14.00
Number of registered nurse training folders reviewed.	8.00
Number of registered nurse training folders with RN Physical Exam Training.	8.00
Number of training folders with continuing medical education credits.	14.00
Number of training folders with BLS for health care providers or CPR and AED certification.	14.00
Number of radiation safetoy officer training folders with radiation safety training.	0.00
Findings	NO DATA
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	No - See findings below.
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	Schedules placed on SharePoint. The non-traditional schedule request has been emailed ot the RHSA. (b)(5)
Deliverables	NO DATA

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IHSC Health Systems Assessment

Facility Overview

Months: June / July / August **Bed Capacity:** 1895 **MHU Beds:**

Daily Census: 1743 **Male:** 1561 **Female:** 224 **Juveniles:** 2 **LOS:** 55 days

Average Number of Encounters					
Category	**Month 1**	**Month 2**	**Month 3**	**Average**	**% pop**
Pre-screening	1304	1343	1781	1476	84.7
Intake	1597	1819	2627	2014	115.6
Physical Exams	1046	977	990	1004	57.6
Vitals/Labs	281	345	315	314	18.0
Sick call	1813	1558	1660	1677	96.2
Pros/Imm	2009	948	988	1315	75.4
Acute	109	88	143	113	6.4
Chronic	94	71	114	93	5.3
Mental Health	489	366	412	422	24.2
Dental	160	112	138	137	8.0
Emergent/Urgent	617	480	571	556	31.9
MHU	810	768	850	809	46.4
Seg	764	620	676	687	39.4
Admin	476	456	573	502	28.8
Transfers	1512	1407	1768	1562	89.6
Totals	13081	11383	13429	12631	725.0
Pill-line passes					
RX (Pill-line + KOP)	1798	1732	1867	1799	103.2
Referrals / ER	108	92	101	100	5.7

Staffing					
	PHS	**GS**	**CTR**	**Vacant**	**Total**
(b)(7)(E)					

AMERICAN OVERSIGHT

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PRE-ARRIVAL REVIEW

Accreditation

Most recent ACA, NCCHC, and PBNDS surveys. List type of survey and date.

Evaluation Method		
Survey	**Date**	**Findings / Recommendations**
PBNDS	3/20/2018 to 3/22/20181	No findings
NCCHC	4/22/2018	J-G-05

NCCHC Findings: Suicide Prevention Program 1d (2d in 2018 manual). standard was not met. "Nonacutely suicidal inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.

Recommendations (b)(5)

(b)(5)

Comments STDC communicated to auditors that the watch is continuous while the documentation is every 15 minutes.

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Grievances

Evaluation Method:	Observation	
Items to Review *(review 100% during past year)*	**Yes, No, or N/A**	**Comments**
1. Have there been any medical grievances reported through QI/JIC/CRCL/DRIL *(if so, provide type in comment section)*	NO	
2. Is there a local procedure (SOP) for managing grievances?	YES	
3. Is there an identified grievance officer?	YES	
4. Is the log book kept and up to date?	YES	
5. Were all Grievances addressed in a timely manner?	YES	
6. Number of Formal/Informal grievances: 0 20 / 3 0		

Findings/ Recommendations:	. No findings
Deliverables:	**N/A**

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Incident Reports/RCA/SOE

Evaluation Method:			
Items to Review *(review 100% during past year)*		**Yes, No, or N/A**	**Comments**
1. Were there any trends noted from reported incident reports or RCAs for FY17?		NO	No significant upward trends were noted.
2. Are there any active RCAs/SOE?		NO	
3. Has a RCA or SOE been completed during this FY? If so, complete #4		NO	
4. Was a CAP initiated and/or completed for the RCA or SOE?		N/A	
a. If CAP initiated, note status and due date.		N/A	
Findings/ Recommendations:			
Deliverables:			

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On-Site Observations

During site observations, the reviewers should observe staff members carrying out the task, interview staff, review medical records and review supporting documents (i.e. logs, minutes, binders, electronic trackers, etc.).

Medication Administration (Observations-Onsite Review)

Question (10 ENCOUNTERS)	Improvement Plan (1,2, or 3)	Comments
Is pre-pouring occurring? **(Be sure to observe more than one nurse on multiple shifts) Level 2@100%**	N/A	Observed 4 nurses on 2 shifts 0% pre-pour
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)? **Level 2 @100%**	N/A	4/4 @ 100%
Are mouth checks being conducted with every administration? Observe 10 patients (if possible) on multiple shifts **Level 1 @80%**	N/A	4/4 @ 100%
Are all entries in the MAR complete (allergies, staff initials, etc.)? Observe 10 different MAR; **Level 1 @80%**	N/A	10/10 100%
Are nurses documenting the medication administration immediately after the medication is administered**? Level 2 @100%**	N/A	4/4 @ 100%
Number of all medication refusals documented on the MAR/eMAR **Denominator**	N/A	4/6 refusales; 6/6 notified; 6/27 mars

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Of the identified medication refusals from the MAR, how many refusals did have an accompanying signed refusal form? **Level 2@90%** .	2	
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal in eCW **Level 1 @100%; See guide eon ECW notification**	0	

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Emergency Preparedness and Response

Question	Improvement Plan (1,2, or 3)	Comments
Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)? Refer to guide: **level 1 @90%** Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)? Refer to guide **level 1 @90%** Is there documentation showing completed date and time of mass casualty drills * (each shift should have a complete drill within a three year period)? *Table top/mock drills are acceptable replacements for drills not conducted facility wide Refer to guide: **level 1 @90%** Are clinic staff trained on emergency equipment (AED, first Aid kits, fire extinguisher, etc?) Yes/No **level 1 @90%**	0	
Do emergency scenarios vary? Yes/No?? **Level 100% if No**	N/A	Yes
Is the difference between a drill and an actual event evident in the write-up?): **Level 1 @100%**	N/A	Yes
Is there process in place to distribute "an after-action report to all staff? **Level 1 @90%:**	N/A	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event? **Level 1 @100%**	N/A	Yes
Comments:		
Deliverables:		

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Consent Forms

	Section Completed Under the Pre-Audit Chart Reviews		
	Question	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1.	Number of consent forms (General consent) that were complete (not missing detainee signature, witness, or date). **Level 1 @100%:** Can escalate to Level 2 if not resolved by the completion of the assessment	N/A	25 reviewed
2.	Number of dental consent forms among the identified consent forms.	N/A	5
3.	Number of dental consent forms that were complete (missing detainee signature, witness, or date) **Level 1 @90%**	N/A	5 reviewed
4.	Number of psychotropic consent forms among the identified consent forms.	N/A	5
5.	Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date) **(Level 1 @90%)**	N/A	5 reviewed
Findings/ Recommendations:	Transfer Summaries completed in the pre-audit Chart Reviews		No findings
Deliverables:	None		

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Transfers

Reviewer

Evaluation Method:	**Section Completed Under the Pre-Audit Chart Reviews**	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of outgoing transfers authenticated appropriately (signed, stamped, and dated): **Level 1 @100%**	N/A	100%
2. Number of outgoing transfers completed by LVN or above. **Level 1 @100%,**	N/A	100%
3. Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility) Level 2 @90%	N/A	100%
4. Of the 25 transfers reviewed for TB clearance documentation, how many correctly documented no TB treatment status? **see guide Level 2@90%**	N/A	100%
5. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented no TB treatment status? see guide **Level 2@90%**	N/A	100%
6. Of the 25 transfers reviewed for TB clearance documentation, how many - correctly documented TB treatment status? see guide: **Level 2@90%**	N/A	100%
7. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented TB treatment status? see guide: **Level 2@90%**	N/A	100%

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Findings/ Recommendations:	All transfers reviewed followed guidelines appropriately.
Deliverables:	

Pre-Screening

Reviewer:

Evaluation Method:	**Observe 10 pre-screens if Possible**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of prescreen encounters observed. **Denominator**	10	
2. Are language services being used during pre-screen if appropriate? **Level 2: if No**		100% completed.
3. Number of prescreens with documentation completed in eCW prior to intake screening. **Denominator**	10	
4. Number of prescreen encounters prioritized. **Level 1: @90%**		100% completed.
5. Number of Pre-screens encounters not prioritized appropriately: **Level 1 @90%**		100% completed.
Findings/ Recommendations:	No findings	

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Intake Screening

Evaluation Method:	Observe 10 "Intakes" if Possible		
Items to Review *(review 25 records in the past month)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of intake screenings observed. (N/A) **Denominator**		10	
2. Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening. **Level 1 @90%**		N/A	100%
3. Number of intake screening observations where a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat were taken. **Level 2: @90%**		N/A	100%
4. Number of intake screening observations that used language services. **Level 2:@90%**		N/A	100%
5. Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)? **Level 1 @90%**		N/A	100%
6. Of the intake screening observations that used language services, how many were appropriately conducted? **Level 2:@90%**		N/A	100%
7. Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide. **Level 2:@90%**		N/A	100%

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8. Number of intake screening observations with security advice of special needs and housing disposition. **Level 1 @90%**	N/A	
Intake screenings are correctly being done and documented in eCW per IHSC policy.		
Deliverables:	No findings.	

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Chronic Care

Evaluation Method:	Observe 10 "Chronic Care Encounters"		
Questions		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of chronic care encounters observed that utilized language services appropriately. **Level 2 @90%**		N/A	100%
2. Number of chronic care encounters observed that were completed within the time frame indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit **Level 2 @90%**		N/A	100%
3. Number of chronic care encounters observed that were not completed within the timeframe indicated by a previous visit (greater than 90 days for unstable patients). **Level 2 @90%**		N/A	100%
Findings/ Recommendations:	No findings. Best Practice: Pearsall uses Rendering Provider model for 9 CQI managed Chronic conditions to ensure continuity of care. Morning Provider Huddle ensures all scheduled detainees are seen on a daily basis.		
Deliverables:	N/A		

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Physical Exams

Evaluation Method:	Observe 10 physical exams completed by different providers	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of physical examination encounters with a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken **Level 2@90%**	N/A	10 Physical exams observed, and 35 charts reviewed
2. Number of physical examination encounters observed that were completed within the specified timeframe. (Two Business days for PE-Cs, 7 days for –juveniles and, 14-days for adults) **Level 2@90%**	N/A	The majority of the PE's observed and reviewed have been completed at day #10, and several of them were completed at day #7 & 8
3. Number of physical examination encounters observed that offered detainee provider referral when appropriate **Level 1 @90%**	N/A	Of all the PE's observed and reviewed, none of them needed a referral to higher level of care.
Findings/ Recommendations:		
Deliverables:		

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Sick Call

Evaluation Method:	**Observation**		
Items to Review *(Observe 10 "Sick Call "Encounters if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Is sick call offered face-to-face on a daily basis?? **Level 1 if NO**		N/A	YES
2. Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented) **Level 1; if NO**		N/A	YES
3. Is translator services offered when appropriate during a sick call process? **Level 1; if NO**		N/A	YES
4. Did RN utilize nursing protocols/guidelines during sick call encounters?		N/A	YES
5. Is a guardian present for any minor (<18 years of age) sick call? **Level 1; if NO and applicable**		N/A	
6. Is there a sick call log used to document all encounters?		N/A	YES
Findings/ Recommendations:	No findings.		
Deliverables:			

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Medical Housing Unit 23 hr Observation

Evaluation		
Items to Review *(Observe 10 MHU 23-HR OBS if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU 23 hour observation records reviewed. **Denominator**	N/A	10 records reviewed
2. Number of MHU 23 hour observation records with documentation regarding return to general population	N/A	100%
3. Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis documented on placement in the medical housing unit	N/A	100%
4. Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 2 business day. **Level 1: @80%**	N/A	3/3: 100%
Findings/ Recommendations:	There is no eBO report for 23 hour observation records; sorted through Kardex in PodShare to obtain records.	
Deliverables:		

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Medical Housing Unit full Admission Observation

Evaluation Method:	Observation	
Items to Review *(10 detainees if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are all patients within sight or hearing of a qualified health professional? **Yes/No**??	N/A	Yes
2. Number of nurses in the MHU at time of observation **(Denominator)**	N/A	2
3. Number of patients in the MHU at time of observation	N/A	9
4. Number of MHU full admission records with 24 hour chart reviews every day. (Review one 24-hour chart in detail to confirm review was done appropriately) **Level 1: @90%**	N/A	4 of 4: 100% with admission charts with a 24 hour chart check completed
5. Number of MHU full admission records with all medications (except KOP med exceptions see guide) placed on pill line. **Level 2 @90%**	N/A	4 of 4: 100% admissions with correct medications on PL
Findings/ Recommendations:	No findings	
Deliverables:		

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Suicide Watch- Observations

Evaluation Method:	None observed on Site		
Items to Review *(Observe 10 detainees on "suicide watch" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of patients on suicide watch **Denominator**		N/A	No suicide watch observed
2. Number of patients on suicide watch with nursing assessment performed within the past 8 hours. **Level 3 @ 100%**		N/A	2
3. Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule. **Level 3@100%.**		N/A	Preprinted times on Suicide Observation check list is not staggered. 15 min checks completed per suicide observation checklist
4. Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours. **Level 3 @ 100%.**		N/A	2
5. Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc). **Level 3@100%**		N/A	2
Findings/ Recommendations:	Pending HQ to release new Observation and Watch Checklist which removes the pre-printed times. This was noted as a deficiency in our recent NCCHC audit.		
Deliverables:			

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Hunger Strike - Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees on "Hunger Strike" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Was water available to detainees on hunger strike? **Level 3: if NO @90%**		N/A	100%
2. Were meals (if observed during meal times) offered to patient and how MUCH OF THE of the food SERVED was eaten **Level 3: If NO @90%**		N/A	100%
3. Of the hunger strike records with special needs, how many records indicate that the needs were addressed? **Level 3 @90%**		N/A	Documented on RN daily notes
Findings/ Recommendations:	Note: No detainee on Hunger Strike during time of review. Chart review performed.		
Deliverables:			

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Segregation- Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees in "Segregation" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU full admission records for patients in segregation for medical overflow. **(Denominator)**			5 Detainees reviewed
2. Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on every 8 hours according to MHU policy **Level 3 @90%**			5 Detainees rounded on
3. Was sick call offered to detainees in segregation or other specialty housing units? **Level 2 @90%**			5 out of 5 Detainees offered sick call
Findings/ Recommendations:	No findings		
Deliverables:			

AMERICAN OVERSIGHT

After-Hours Medication (night pharmacy)

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of after-hours medication log records reviewed. **(Denominator)**	N/A	10 after hours medication reviewed. 7 of the after hours medication were ordered by APP after hours
2. Number of after-hours medication LOG records that were generated by a nurse as a telephone order. **Level 2 @90%**	N/A	2
3. Number of afterhours medication records that were generated by a nurse as a telephone order and were signed by a provider within 24 hours returning for next work shift **Level 2 @90%**	Level 2 -90%	2 generated by RN. (b)(6); (b)(7)(C) received inhaler from night pharmacy during intake but was not documented as TE to provider (not signed by APP), however it was documented in the log that two provider RN and APP signed out the medication
4. Does the pharmacy have a reconciliation process?: **Level 2 if NO @90%**	N/A	yes-100%
5. Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed from the AHC: **Level 1 @100%**	N/A	yes-100%
6. Is all necessary information entered the fields of the After-Hours Cabinet (AHC) sign out log. **Level 1 @100%**	N/A	All information was entered in all 10 cases
7. Is a medication log in place and reflective of quantities of medication	N/A	yes-100%

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stored in the night cabinet? **(Level 1 if NO)**		
8. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed? **Level 2 @100%: if NO**	N/A	yes-100%
9. Is the after-hours verbal medication order entered eCW by the prescriber upon return to duty? **Level 2@100%**	N/A	yes-100%
10. Is the after-hours medication administration properly documented on the MAR or in the electronic health record? **Level 2@100%**	N/A	yes
11. Is the night cabinet, clean, stocked, and organized?	N/A	yes
12. Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications? **Level 2 @100%**	N/A	yes
Findings/ Recommendations	None	
Deliverables:	None	

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Language Access- Observations

Reviewer:

Evaluation Method:	**Observation**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are the "I Speak" posters and pocket guides readily available and posted in the clinic?		Posted in intake
2. Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities? **If No; level 2; @100%**		Yes
Findings/ Recommendations:	Site also has Video Sign Language Interpretation through GEO @ Nurse's station and Stratus Video Interpretation APP on all Gov iPhones contracted with IHSC	
Deliverables:		

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Diagnostic Services

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are laboratory services provided in adherence with CLIA Waived testing? **Level 3: @90%**	3	No. Glucometer control incomplete 7/12/18. Urine HCG control log last updated 12/19/17. Urine dipstick control log last updated 8/2015.
2. Is there a current certificate for CLIA-waived testing? **Level 2@100%: CLIA services stopped until obtained.**	N/A	Yes. Certificate displayed with effective dates 8/9/17 to 8/8/19.
3. Are radiation signs posted on all doors leading to areas with radiation producing equipment? **Level 1 @100%, "SPOT-FIX, may escalate to Tier 2 If multiple rooms noted not addressed by the end of the visit**	N/A	Yes. Dental & main radiology doors.
4. Are Dosimetry reports reviewed quarterly (MONTHLY FOR DECLARED PREGNACIES) by the Compliance officer or HSA? (Yes/No): **If No level 2@100%**	N/A	Yes
5. Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment? **Level 2@100%**	N/A	Yes.

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6. Are staff dosimeter badges and controls stored in a central location and not near a radioactive source? **Level 2@ 100%**	N/A	Yes. In office hallway, not near known radioactive sources.
Findings/ Recommendations:	Laboratory Controls not being properly performed. (b)(5)	
Deliverables:		

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Log Books

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of pharmacy refrigerator temperature logs reviewed **(Denominator)**	N/A	2 logs reviewed: MHU and Lab
2. Number of pharmacy refrigerator temperature logs that have entries per shift for the past three months. **Level 1 @90%**	N/A	92% 7 days not signed off / 90 entries were counted.
3. Number of refrigerator temperature logs that are out of range. **(Denominator)**	N/A	0
4. Of the refrigerator temperature logs that are out of range, how many logs have documentation of action taken and follow-up ?(**Level 1 @90%)**	N/A	
Are the sharps secured and count accurate? **Level 2 @100%, if NO**	N/A	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes ?(**Level 1 @90%)**	N/A	Yes
Are the narcotics secured, (double locked) and counts within the last 3 months accurate (clinic and pharmacy supply)? **Level 3 @90%**	N/A	Yes
In review of 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts? **Level 1 @90%**	N/A	Yes

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Are the urgent care cart/trauma bag and AEDS checked daily for content (signatures, AED functionality, and expiration for the past 3 months? **Level 2 @90%**		
Findings/ Recommendations:	No findings	

Daily Assignment Sheet (DAS)

Evaluation Method:	Observation	
Items to Review *(review 10 random days)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of daily assignment sheets reviewed per month) **Denominator**	N/A	10 total observed: 100%
2. Number of daily assignment sheets that were archived appropriately.	80%	*No IP level; Observation only for 2018 audits*
3. Number of daily assignment sheets reviewed had at least one emergency team identified per shift. **Level 1 @90%**	N/A	On every sheet reviewed, at least one shift did not report who was the emergency team. Most of the time, that was third shift.
Findings/ Recommendations:	None (b)(5)	
Deliverables:	None	

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Shift Report and Time-cards

Reviewer:

Evaluation Method:	Observation		
Items to Review *(audit 10 random cards)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are shift reports conducted?		*Yes*	*No IP level: best practice*
2. Is there at least one representative from each department?		*Yes*	*No IP level: best practice*
3. Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?		*Yes*	*No IP level Observation only for 2018 audits*
Findings/ Recommendations:	No findings		
Deliverables:			

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Meetings

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the two previous staff meetings, how many were conducted monthly and properly documented? **Level 1 @80%**		N/A	2 of 2: 100%
2. Out of the two previous public health, safety, and preparedness meetings, how many were properly documented? (**Level 1 @80%)**		N/A	2 of 2: 100%
3. Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented? **(Level 1 @80%)**		N/A	2 of 2: 100%
4. Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented. **Level 1 @80%**		N/A	2 of 2: 100%
Findings/ Recommendations:	**None** No findings or recommendations		
Deliverables:	None		

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PERSONNEL

Personnel and Credentialing Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files each if available*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the 12 personnel and credentialing files reviewed how many were PHS officers **No IP level**	N/A	3
2. Of the 12 personnel and credentialing files reviewed how many were federal civil service employee **No IP level**	N/A	0
3. Of the 12 personnel and credentialing files reviewed how many were contractors	N/A	9
4. Does the facility have a process for tracking requirements electronically?: **No IP level**	N/A	YES
5. Of the 12 personnel and credentialing files reviewed how many records are for privileged staff (physician, psychiatrist, psychologist, dentist, and social worker)?: **No IP level**	N/A	2
6. Of the 12 Privileged staff that are Licensed Independent Practitioners (LIPs) how many had current personnel files records current? (Yes/No) **Level 2@100%**	N/A	2 of 2: 100%
7. Of the 12 personnel files reviewed, how many contained a current and signed Health and Ability form? **Level 1 @90%**	N/A	12 of 12: 100%
8. Of the 12 personnel files reviewed, how many contained a signed statement of confidentiality (one –time statement signed by	N/A	12 of 12: 100%

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staff) **Level 1; @90%**		
9. Of the 12 personnel files reviewed, how many contained a signed statement of risks and responsibility (one time)?	Level 1	8 of 12: 66.67%
10. Of the 12 personnel files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time). **Level 1; @90%**	Level 1	8 of 12: 66.67%
11. Of the 12 personnel files reviewed how many contained a signed release of information form (one time). **Level 1; @90%**	N/A	12 of 12: 100%
13.Of the 12 credentialing files reviewed, how many contained current, valid, and unrestricted license **Level 3: if not 100%**	N/A	12 of 12: 100%
14. Of the 12 credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification **Level 1 @90%**	N/A	12 of 12: 100%
15. Of the 12 credentialing files reviewed how many were reviewed for physicians or psychiatrists.	N/A	0
16. Of the 12 credentialing files reviewed for physician or psychiatrist how many had documentation of residency. **Level 2@90%**	N/A	No physician or psychiatrists files were evaluated
17. Of the 12 credentialing files reviewed how many board certified physician or psychiatrist had documentation of board certification. **Level 2 @90%**	N/A	No physician or psychiatrists files were evaluated
18. Of the 12 credentialing files reviewed how many had a copy of a curriculum vitae or a resume. **Level 1 @90%**	N/A	12 of 12: 100%
15. Of the 12 credentialing files reviewed how		9 of 12: 75%

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many PHS officers had at least two years of evaluations (COERS). **Level 1 @90%**	Level 1	
19. Of the 12 credentialing files reviewed how many had current National Provider Data Bank information. (renewable every 2 years) **No IP level**	N/A	2 of 2: 100%
20. Of the 12 credentialing files reviewed how many had scope of practice documentation (Pertinent staff only) **Level 1 @90%**	Level 1	10 of 12: 83%: 1 PharmD and 1 RN did not have Scope of Practice
21. Of the 12 credentialing files reviewed for LIPs how many had a competency assessment or peer review. **Level 2 @90%**	N/A	2 of 2: 100%
22. Of the 12 personnel files reviewed, how many contained training folders with HSD-500 record. **No IP level**	N/A	Training Files are separate
23. Of the 12 personnel files reviewed, how many contained training folders with a signed position description. **No IP level**	N/A	*No IP level Observation only for 2018 audits* Training Files are seperate
24. Of the 12 personnel files reviewed, how many contained registered nurse training folders reviewed. **No IP level**	N/A	*No IP level Observation only for 2018 audits*
25. Of the RN personnel files reviewed, how many contained registered nurse training folders with RN Physical Exam Training. **No IP level**	N/A	100%: Training Files are separate: RN PE Training was documented in 5 of 5 files in Training File.
26. Of the 12 personnel files reviewed, how many contained continuing medical education credits. **No IP level**	No IP level	3 of 12: 25%
27. Of the 12 personnel files reviewed, how many contained BLS for health care providers or CPR and AED certification. **Level 1 @90%**	N/A	12 of 12: 100%

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Employee Health Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are employee health files kept separate from other files? (Yes/No) **No IP level**	N/A	Yes
2. Is access to employee records limited to the compliance officer, HSA, and AHSA(s) and AA? **No IP level**	N/A	Yes: Needs expanded to NM with change in NSU
3. Of the twelve-employee health reviewed how many files had past year's TB (PPD or CXR) documentation. **No IP level**	N/A	12 of 12: 100%
4. Of the twelve-employee health reviewed how many files had Hepatitis B vaccination or declination form. **No IP level**	N/A	*No IP level Observation only for 2018 audits*
5. Of the twelve-employee health reviewed how many files had yearly Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing). **Level 1 @80%**	Level 1	0 of 12: 0%: No dates. Completed upon hire but not annually. Documented on spreadsheet completion but not in file. Form created to properly document in Credentialing File
6. Of the twelve employee health reviewed how many files had yearly respirator medical clearance. **Level 1 @80%**	N/A	10 of 12: 83%; 2 employees annual was late
7. Of the twelve employee health reviewed how many files had yearly respirator fit test. **Level 1 @80%**	N/A	10 of 12: 83%: 2 employees annual was late
8. Of the twelve employee health reviewed how many files had with emergency contacts.	N/A	In Credentialing File not Employee Health File
9. Are staff injuries and illnesses documented on the Workforce Injury Tool? **Level 2 @90%**	N/A	None found

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Findings/ Recommendations:	Level 1 IP for #5, 10,11,15; #26 no IP however needs improvement
Deliverables:	

Training

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 12 Files)* ***No IP level***		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the twelve training folders reviewed how many had documentation of completed Mandatory ICE Trainings (see guide for list of trainings)		N/A	100%: All Mandatory ICE Trainings completed through PALMS.
2. Of the twelve training folders reviewed how many had documentation of completed IHSC Mandatory Trainings(see guide for list of trainings)		N/A	100%: All IHSC Mandatory Trainings completed through PALMS.
3. Of the twelve training folders reviewed how many had documentation of Completed Emergency preparedness Trainings(see guide for list of trainings)		N/A	All Emergency Preparedness trainings completed through PALMS.
4. Of the twelve training folders reviewed how many had documentation of completed Occupational Health Trainings (see guide for list of trainings)		N/A	All Occupational health trainings completed through PALMS

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5. Of the twelve training folders reviewed how many had documentation of completed TB Management Trainings	N/A	100%: All TB management trainings completed through palms
6. Of the twelve training folders reviewed how many had documentation of completed Mental Health Training for Behavioral Health Providers (see guide for list of trainings)	N/A	100%: All mental health trainings completed through palms
Findings/ Recommendations:	No findings	
Deliverables:		

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Schedules

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 3 months Schedules)* *****No IP levels*****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the three month schedules reviewed, how many had a legend to explain codes.		N/A	3/3: 100%
2. Out of the three month schedules reviewed, how many had staff assigned 40 HRS PER WEEK20" per scheduling period.(Refer to guide)		N/A	3/3: 100%
3. Out of the three month schedules reviewed, how many had provider coverage on weekend/holidays.		N/A	3/3: 100%
4. Out of the three month schedules reviewed, how many had actual work hours reflected for non-traditional shifts.		N/A	3/3: 100%
5. Out of the three month schedules reviewed, how many had signed approvals for non-traditional shifts?		N/A	3/3: 100%
6. Out of the three month schedules reviewed, how many had a PDF copy each time a change was made to the schedule?		N/A	3/3: 100%
Findings/ Recommendations:	No findings		
Deliverables:	N/A		

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Summary

Topic	Recommendation
Staffing	Needs to include: PM; ICO; NM; PMHNP. Does this include FT & CSL Staff?
Medication Administration	Pg 7 & 8: Squares are too big and not fillable
Chronic Care	Replace word "stable" with "controlled" e.g. Many detainees may be "stable" but be outside
	of the CQI control recommendations. As with A1C for a DM or B/P for HTN
MHU 23 hour Observation	Create eBO Report for 23 OBS; Had to find detainees by going through old Kardex
CLIA Waived Testing	Further define requirements for adherence with CLIA Waived testing requirements.
Personnel/Credentialing Files	Organize this section so it matches the layout of the folders. There was a lot of flipping back
	and forth throughout the audit process.
Training Files	Credentialing Section (pg 33): Training Files separate from Credential Files. Move question
	#22, #23, #24, #25, #26 into Training section on page 35
Employee Health Files	Question #8: Emergency Contact part of Credential File not Employee Health File

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Recommendations from Facility

Suicide Watch Observations: Observation and Watch Checklist form has been revised to remove pre-printed times

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Additional Comments *(include Section and item number)*

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Deliverables

Topic	Items	Due	Lead
Medication Refusals	Level 1: 66% of Med Refusals had accompanying signed refusal form	9/5/2018	(b)(6); (b)(7)(C)
After-Hours Meds	Level 1: 90%: 2 did not have TE to provider for inhaler orders	9/5/2018	
Lab Services	Level 2: Control Logs not being completed per CLIA requirements	9/5/2018	
COERS	Level 1: PHS officers credential files did not contain last 2 COERS	9/5/2018	
Scope of Practice	Level 1: 83% had scope of practice documented in credential file	9/5/2018	
Ishihara Test	Level 1: Documented on spreadsheet with no date. New form created	9/5/2018	

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Unit Chiefs and Leadership Review Comment & Feedback

Leadership	Recommendations/ Comments/ Feedback
Chief of Health Operations	
Chief Advance Practice Practitioner	
Chief of PHSP	
Chief of Nursing Services Unit	
Chief of Medical Quality Management	
DAD-Administration	
DAD-Health Systems Support	
DAD Healthcare Compliance	
DAD Clinical Services Review	
Chief Medical Officer Review	
Chief of Staff Review	
AD, IHSC Review	

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Chief of Health Operations

_____

Signature

Chief Advance Practice Practitioner

_____

Signature

Chief of Public Health Safety and Preparedness Unit

_____

Signature

Chief of Nursing Services Unit

_____

Signature

Chief Medical Quality Management Unit

_____

Signature

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Leadership Signatures

DAD Health Systems Support _____

Signature

DAD Healthcare Compliance _____

Signature

DAD Administration _____

Signature

DAD Clinical Services Review _____

Signature

Chief Medical Officer Review _____

Signature

Chief of Staff Review _____

Signature

AD, IHSC Review Status _____

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined

Assessment Information - Report Complete

Facility	Pearsall
Site visit start date	2019-02-19
Site visit end date	2019-02-22
Fiscal Year	FY2019
Fiscal Quarter	Q2
Post-audit corrective action identified	No
Immediate corrective action identified	Immediate Corrective Action Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Review Complete
DAD, Health Care Compliance Review Status	Review Complete
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	No data reported

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Facility Information - Review Complete

Facility HSA	
Regional HSA	
Bed Capacity	1852
MHU Beds	20
Daily Adult Male Population	1439
Daily Adult Female Population	269
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	60
Facility Information Comments	None

Average Number of Encounters (Past 3 Months)

Prescreenings	1523
Intake Screenings	1567
Physical Examinations	1000
Vitals/Labs	626
Sick Call	2038
Pros/Imm	748
Acute	202
Chronic	82
Mental Health	1538
Dental	134
Emergent/Urgent	367
MHU	1538
Segregation	716
Admin	53
Transfers	1679
Pill-Line Passes	21689
Prescriptions (Pill-line + KOP)	2404
Referrals/ER	165

Accreditation - Review Complete

Last ACA Accreditation	2016-12-05T05:00:00Z
Last ACA Findings	

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	100% on all applicable mandatory standards 98.7% on all applicable non-mandatory standards Finding on non-mandatory standard 1-HC-1A-17: The facility does not complete a full dental exam by a dentist on all detainees within the first 30 days. NOTE: Under ACA's Health Care (HC) standards, a full dental exam within the first 30 days is required. However, in 2018 IHSC facilities began to be surveyed under ACA's ALDF standards, which requires a full dental exam within 1 year.
Last NCCHC Accreditation	2018-02-26T05:00:00Z
Last NCCHC Findings	J-G-05: Suicide Prevention Program The facility has provided additional documentation to support its compliance with J-G-05, specifically, that non-acutely suicidal detainees should be monitored on an unpredictable scheduled (not to exceed 15 minutes). The additional documentation has been submitted to NCCHC, and IHSC is awaiting an Update Report from NCCHC to indicate whether they feel the standard is now met.
Last PBNDS Accreditation	2018-03-20T04:00:00Z
Last PBNDS Findings	No data reported
Accreditation Comments	No data reported

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	10
Of the after hours med log records reviewed, how many records documented the patient's identification number?	10
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	10
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	3
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	No Par Level Noted.
After Hours Medication Chart Review Deliverables	See CAP.

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	No
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes

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Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	Yes
After Hours Medication Encounters Findings	There is not a log in place that identifies how many meds are in the after hours cart. Nurses sign out meds, but there isn't a par level to verify how many are left for accountability. Pharmacist stated this was a low priority for him. Sometimes meds are signed out the next day.
After Hours Medication Encounters Deliverables	(b)(5)

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	24
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	13
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	13
Of the chronic care records reviewed, how many detainees had psychiatric medications?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	2
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	12
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	12
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	13
	13

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Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	25
Chronic Care Records Findings	No data reported
Chronic Care Records Deliverables	No data reported

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	10
Of chronic care encounters observed, how many were considered stable patients?	10
Of the stable patients observed, how many were completed within the appropriate timeframe?	10
Of chronic care encounters observed, how many were considered unstable patients?	0
Of the unstable patients observed, how many were completed within the appropriate timeframe?	0
Of the chronic care encounters observed, how many had a treatment plan?	10
Chronic Care Encounters Findings	None
Chronic Care Encounters Deliverables	None

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	25
Of the general consent forms reviewed, how many were complete?	25
Of the consent forms reviewed, how many were dental consent forms?	14
Of the dental consent forms reviewed, how many were complete?	14
Of the consent forms reviewed, how many were psychotropic consent forms?	11
Of the psychotropic consent forms reviewed, how many were complete?	11
Consent Forms Findings	No data reported
Consent Forms Deliverables	No data reported

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Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	108
Of the daily assignment sheets reviewed, how many were archived appropriately?	108
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	108
Daily Assignment Sheets Findings	None
Daily Assignment Sheets Deliverables	None

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	None
Diagnostic Services Deliverables	None

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
	Yes

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Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	
Is there a system in place to distribute an after-action report to all staff?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	none
Emergency Preparedness and Response Deliverables	n/a

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	No
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	Daily, weekly, monthly, PHSP checklists not currently accessible. However, local HOU does perform daily walk-thrus which are documentd and the monthly Health & Safety assessments via SharePoint are completed.
Environmental Health Deliverables	(b)(5)

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	0
Is there a local SOP for managing grievances?	No
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0

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Number of formal grievances.	0
Number of informal grievances.	28
Grievances Findings	None
Grievances Deliverables	n/a

Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	1
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	1
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	1
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	1
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	1
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	1
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	1
Hunger Strike Records Findings	None
Hunger Strike Records Deliverables	n/a

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
	0

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Of the patients on a hunger strike, how many was water available for?	
Of the patients on a hunger strike, how many were offered meals?	0
Of the patients on a hunger strike who were offered food, how much food was offered?	n/a
Of the food offered, how much of the food was eaten?	n/a
Of the patients on a hunger strike, how many had special needs?	0
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	n/a
Hunger Strike Encounters Deliverables	n/a

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	None
Infectious Disease Prevention Deliverables	n/a

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	24
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	5
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	20
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	0
Of the records with a pain scale greater than 0, how many were assessed?	0

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Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	3
Of the intake records with clinically significant findings, how many were referred appropriately?	3
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	25
Intake Screen Records Findings	Column J, Question Did the intake screening use the eCW template?: No, Possibly an old saved template, Pain and Translator section is combined with intake information.
Intake Screen Records Deliverables	Please inform staff members to use current intake templates. ***Last question is not listed on audit tool.

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	16
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	16
Of the intake screen encounters observed, how many included a full set of vital signs?	16
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	16
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	16
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	16
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	0
Intake Screen Encounters Findings	None
Intake Screen Encounters Deliverables	None

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25

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Of the language access records reviewed, how many addressed and documented the use of a translator?	7
Of the language access records reviewed, how many did not use a translator?	18
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	17
Language Access Records Findings	One sick Call encounter documented the use of an interpretor. However, the Interpreter name or number was not llisted. (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Visit date 01/18/2019
Language Access Records Deliverables	No data reported

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	None
Language Access Encounter Deliverables	n/a

Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	2
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	2
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	No
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	Yes

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Log Books Findings	There were 7 shift counts that did not have two signatures. HSA was informed and corrected on spot.
Log Books Deliverables	None

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	25
Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	25
Of the medication administrations observed, how many mouth checks were conducted?	25
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	25
How many MAR entries were observed?	25
Of the MAR entries observed, how many were complete?	25
Of the MAR entries observed, how many medication refusals were documented?	0
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	0
Of the identified medication refusals, how many were high-risk medications?	0
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	0
Medication Administration Findings	None
Medication Administration Deliverables	None

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	2
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	None
	n/a

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Meetings Deliverables

MHU Full Admission Chart Review - Review Complete

How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	25
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	25
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	13
Of the MHU full admission records reviewed, how many had a nursing care plan?	25
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	25
Of the MHU full admission records reviewed, how many had patient education provided daily?	25
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	8
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	8
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	0
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	0
MHU Full Admission Records Findings	None
MHU Full Admission Records Deliverables	None

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	4
How many patients are in the MHU full admission at the time of observation?	13
	13

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How many MHU full admission patients have a 24-hour chart review everyday?	
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	8
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	8
MHU Full Admission Encounters Findings	None
MHU Full Admission Encounters Deliverables	None

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	25
Of personnel and credentialing files reviewed, how many were PHS officers?	5
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	5
Of personnel and credentialing files reviewed, how many were federal civil service employees?	0
Of personnel and credentialing files reviewed, how many were contractors?	20
Of personnel and credentialing files reviewed, how many records are for privileged staff?	3
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	3
Of the LIP staff records reviewed, how many had personnel files records current?	3
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	3
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	25
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	25
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	25
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	25
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	25

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Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	25
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	25
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	25
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	9
Of the staff records reviewed, how many had scope of practice documentation if applicable?	25
Personnel and Credentialing Files Findings	None
Personnel and Credentialing Files Deliverables	n/a

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	7
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	7
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	25
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	25
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	0

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Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	25
Of the physical exam charts reviewed, how many were for adult females?	0
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	0
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	0
Physical Exam Records Findings	All the physical Exams reviewed were PE-S.
Physical Exam Records Deliverables	No data reported

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	10
Of the physical exam encounters observed, how many included a full set of vital signs?	10
Of the physical exam encounters observed, how many were completed within the specified timeframe?	10
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	0
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	No data reported
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	10
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	10
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	0
Physical Exam Encounters Findings	None
Physical Exam Encounters Deliverables	n/a

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	16
	Yes

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Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	16
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	3
Prescreen Encounters Findings	None
Prescreen Encounters Deliverables	None

Risk Management - Review Complete

Trends	Trends identified are related to medication errors RE: sMARt implementation. Multiple units invloved. Not unique to the local site. Global issue.
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	0
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0
List all corrective actions identified in the preceding field and note their status and due dates.	None
Risk Management Findings	None
Risk Management Deliverables	n/a

Schedules - Review Complete

How many schedules were reviewed?	3
Of the schedules reviewed, how many had a legend to explain codes?	3
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	3
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	3
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	0
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes

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Schedules Findings	None
Schedules Deliverables	None

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	25
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	24
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	24
Of the segregation records reviewed, how many offered the patient daily sick-call services?	25
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	25
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	25
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	10
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	8
Segregation Records Findings	Note: Several detainees were in seg for a very short period of time (few days). Could not find one seg-clearance note and one daily nursing seg note.
Segregation Records Deliverables	No data reported

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	1
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	1
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	None
Segregation Encounters Deliverables	n/a

Shift Report and Time Cards - Review Complete

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Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	No
Shift Report and Time Cards Findings	GTM initials were not consistantly documented on the time card whene changes were required.
Shift Report and Time Cards Deliverables	Recommendation: (b)(5) (b)(5)

Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	4
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	4
Of the sick call records reviewed, how many included a full set of vital signs?	23
Of the sick call records reviewed, how many had a pain scale greater than 0?	12
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	12
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	21
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	25
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	25
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	Yes
Sick Call Records Findings	When addressing pain and referred to provider must indicate referred for pain and stated reason. Reevaluate pain indicator; perhaps use template for description of pain and flow sheet for actual numerical accountability . *SCR_Num_Guidelines-Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation? 21/22- indicates 22 number of RN's that completed encounter. 3 were completed by APP/CD

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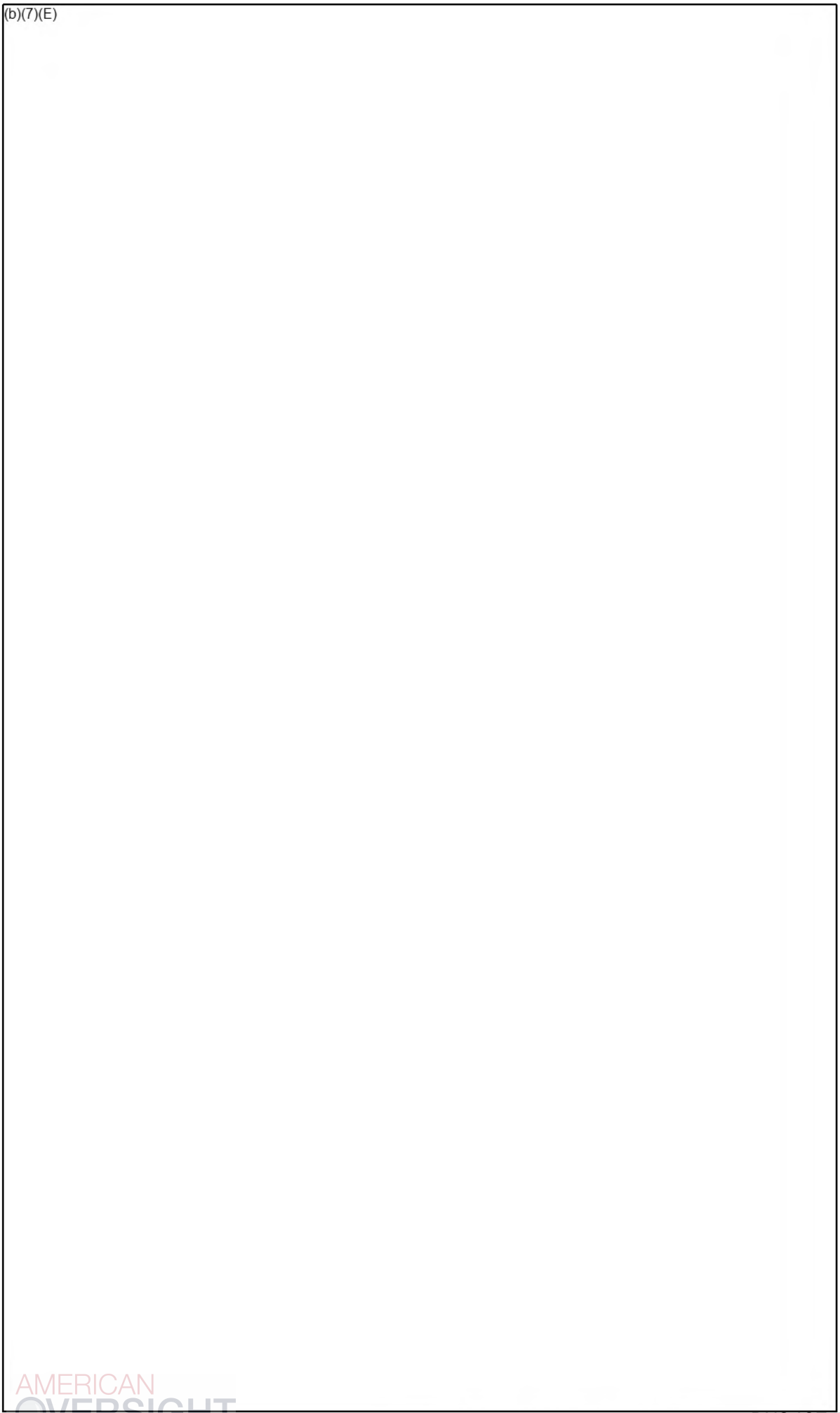
Sick Call Records Deliverables	overall process (good) rating however does have loop hole for perfect storm. Continuity of care excellent . Follow-up by providers should be commended

Staffing Information - Review Complete

(b)(7)(E)

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(b)(7)(E)



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Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed?	6
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	6
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	5
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	5
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	6
Of the suicide watch records, how many had a patient released from suicide watch?	6
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	6
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	6
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	6
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	6
Suicide Watch Pre-Audit Findings	(b)(5)
Suicide Watch Pre-Audit Deliverables	No data reported

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	1
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	1
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	1
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	1
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	1
Suicide Watch Encounters Findings	None
Suicide Watch Encounters Deliverables	n/a

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Training - Review Complete

How many training folders were reviewed?	25
Of the training folders reviewed, how many had a HSD-500?	25
Of the training folders reviewed, how many had a signed position description ?	25
Of the training folders reviewed, how many were registered nurse training folders?	6
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	6
Of the training folders reviewed, how many had continuing medical education credits documented?	25
Training Findings	None
Training Deliverables	n/a

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	18
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	0
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	6
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	1
Transfers Findings	The one incorrect TB transfer summary stated that the patient was not being treated for active TB, yet the standard regimen for TB was listed in the medications section.
Transfers Deliverables	OUt of 25 charts, non were on Chronic medications (i.e. N/A)
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	0
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	0

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Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	15
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	15
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	15
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	15
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	15
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	15
Of the twelve workforce health files reviewed, how many had emergency contacts?	15
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	2018 OSHA Form listed one injury in 2018.
Workforce Health Files Deliverables	None

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	Port Isabel
Start Date	2017-07-23
End Date	2017-07-28
Status	Report Complete
Corrective Action Required?	No
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Complete
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Review Deferred (Team Lead Only)

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Facility Information - Review Complete

Facility HSA	cdr auhl
Regional HSA	cdr van horn
Bed Capacity	1100.00
MHU Beds	42.00
Daily Adult Male Population	1025.00
Daily Adult Female Population	75.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	0.00
Comments	NO DATA

Average Number of Encounters (Past 3 Months)

Prescreenings	1487.00
Intake Screenings	1459.00
Physical Examinations	1338.00
Vitals/Labs	398.00
Sick Call	698.00
Pros/Imm	336.00
Acute	300.00
Chronic	58.00
Mental Health	286.00
Dental	87.00
Emergent/Urgent	99.00
MHU	2605.00
Segregation	37.00
Admin	75.00
Transfers	1478.00
Pill-Line Passes	3524.00
Prescriptions (Pill-line + KOP)	0.00
Referrals/ER	122.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)

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Accreditation - Review Complete

Last ACA Accreditation	2017-06-05
Last ACA Findings	NO DATA
Last NCCHC Accreditation	2016-06-06
Last NCCHC Findings	Last NCCHC survey June 6-8, 2016. Found 100% compliant in all applicable essential standards. Found compliant in 96% of all applicable important standards. (Found not compliant in J-C-02 Clinical Performance Enhancement). J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a written record listing the names of the individuals being reviewed and the date of their most recent review, which included the required elements. However, the clinical performances for mid-level providers had not been completed at the time of the survey. The standard is not met. Corrective action is required for Compliance Indicator #1. The clinical performance of the facility's direct patient care clinicians and RNs and LPNs should be reviewed at least annually. Clinical performance enhancement review processes are designed to enhance competence and address areas in need of improvement. Ultimately, honing the practitioner's clinical skills positively impacts patient care. The following is acceptable documentation for compliance: a log or other written record providing the names of the mid-level providers, the dates of their most recent clinical performance enhancement reviews in accordance with the standard (including the name and credentials of the reviewer), and the signatures of the clinicians being reviewed to attest that the results were shared. Corrective action is required in order to meet this standard. Facility re-accredited.
Last PBNDS Accreditation	2017-01-31
Last PBNDS Findings	No medical findings
Comments	NO DATA

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Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	12.00
Is there a local SOP for managing grievances?	No - See findings below.
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	12.00
Number of formal grievances.	12.00
Number of informal grievances.	0.00
Findings	follows national policy AHSA States they do not have a process in place to receive informal grievances
Deliverables	NO DATA

Risk Management - Review Complete

Trends	No concerning trends noted.
Number of active RCAs/SOEs	0.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	NO DATA
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	No - See findings below.
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	2.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	1. Observed that insulin multi-use vials are marked with "opened on/expires on" stickers; however, it is the insulin box that is labeled, not the vial itelf. 2. Mouthchecks were not completed during this observation. May be an isolated incident with this RN versus systemic issue. 3. Observed that the controlled narcotics and sharps located in the Pill Line room share the same log book/sheet. Would recommend two individual log books. Log book sheet properly provides columns for name, A#, item, #removed or #added; however, 1600 hour insulin syringes are removed in bulk numbers without proper documentation of which detainee the sharp was utilized for. 4. Unable to locate multiple refusal forms in eCW for meds refused on Pill Line.
Deliverables	NO DATA

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	No - See findings below.
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	No - See findings below.
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	N/A - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	Doing mostly real life drills, not many preplanned. Not always hitting every shift every month. Recommend (b)(5)
Deliverables	NO DATA

AMERICAN OVERSIGHT

Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	N/A - See findings below.
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	N/A - See findings below.
Findings	I am told Medical does not store any hazordous chemicals Not up due to time of year.
Deliverables	NO DATA

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	2.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	2.00
Number of psychotropic consent forms among the identified consent forms.	7.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	7.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	2 detainees had dental visits from the charts reviewed and they both had consent forms. 7 detainees reviwed were on psychotropic medications and they all had consent forms.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	19.00
Out of the transfers reviewed, how many had a positive chest X-ray?	10.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	4.00
Out of the transfers reviewed, how many have active TB?	2.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	12.00
Number of transfers with medication instructions clearly provided.	12.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) (TB suspect) transfer summary documents CXR Results: Positive; consistent with TB. No lab results documented to verify non-infectiouness, no note indicting the TB-CM report was attached, transfer summary indicates detainee not being treated for TB, however "Current Medications" list RIPE TB treatment (b)(6); (b)(7)(C) (Active TB case) transfer summary indicates that the detainee is not being treated for active TB, but in the medical history labs indicate positive results for M.TB and medications include TB medications. Transfer summary includes too much information making interpretation of non-infectiousness difficult. A# (b)(6); (b)(7)(C) (Active TB case) transfer summary indicates negative CXR, actual results are positive. Also indicates not on TB treatment but TB medications listed on summary. (b)(6); (b)(7)(C) TB suspect) transfer summary indicates positive CXR and TB-CM attached, however, most current TB-CM

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	note only shows 2 neg smears, everything else is pending, although all smear results are in eCW. A# (b)(6); (b)(7)(C) (TB suspect) transfer summary indicates positive CXR and TB-CM attached, however, most current TB-CM note only shows pending smear results (b)(6); (b)(7)(C) (TB suspect) transfer summary indicated a neg CXR when actual CXR was pos for that date in eCW, also it indicates that patient not on TB treatment buy RIPE TB treatment listed under medications.
Deliverables	NO DATA

Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	25.00
Number of prescreens that used a translator.	0.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	0.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	25.00
Number of prescreens with documentation completed in eCW prior to intake screening.	22.00
Findings	Out of 25 pre-screening charts reviewed, the documentation on three (3) of them was completed in eCW, after the intake screening documentation. No other pre-screening issues identified.
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	8.00
Number of prescreen encounters observed that allowed for patient privacy.	8.00
If privacy was not provided, where was the prescreen performed?	N/A
Number of prescreen encounters that used language services.	0.00
Number of prescreen encounters completed within two hours of arrival.	8.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	8.00
Number of prescreen encounters prioritized.	0.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	0.00
Findings	All 8 prescreens were Spanish-speaking; screening RN was Spanish-speaking. No priority prescreens were identified.
Deliverables	NO DATA

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	0.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	0.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	25.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	25.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	8.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	0.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	0.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	2.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	2.00
Number of intake screenings reviewed by an RN or above within 24 hours.	8.00
Findings	25 Intake charts reviewed. On one chart- Person conducting Intake Screening incorrectly documented that interpreter had been used; they listed themselves as the interpreter for the Intake Screening they conducted. For the purporses of this chart review, I have counted these occurrences as an interpreter NOT being utilized 17 of out 25 charts reviewed- Evidence of TB screening found in the medical record; however, no evidence that it was signed, dated and stamped by a RN or higher Out of the 25 charts reviewed- 10 of the intake screenings were conducted by LVN, thus requiring confirmatory sign-off by RN within 24 hours. Out of those 10 charts, eight (8) had confirmatory sign-off by RN within 24 hours. Two did not.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Intake Screening Observations - Review Complete

Number of intake screenings observed.	4.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	4.00
Number of intake screening observations where a full set of vital signs were taken.	4.00
Number of intake screening observations that used language services.	0.00
Of the intake screening observations that used language services, how many were appropriately conducted?	0.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	4.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	4.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	All 4 detainees screened were Spanish-speaking. RN conducting screenings was Spanish-speaking, thus no interpreter services were utilized. No detainees were identified as requiring any special needs and/or specific housing dispositions.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	25.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	14.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	14.00
Number of chronic care encounters with psychiatric medications.	2.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	2.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	2.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	25.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	13.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	13.00
Findings	(12) charts without a global alert.

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Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	3.00
Number of chronic care encounters observed that utilized language services.	0.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	3.00
Findings	All 3 detainees observed were Spanish-speaking; medical provider was Spanish-speaking. No findings and/or concerns.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	1.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	1.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	1.00
Of the physical examinations with pain assessment, how many were addressed?	1.00
Number of physical examinations with clinically significant findings.	25.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	25.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	24.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	(1) PE-C was not reviewed by MD within 7 day period.
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	4.00
Number of physical examination encounters with a full set of vital signs taken.	4.00
Number of physical examination encounters observed that were completed within 14 days.	4.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	No findings; physical exams performed were thorough and met all requirements. Per IHSC Directive 03-07 Health Assessment, a chaperone is to be used any time a detainee requests one, any time examination of breasts and/or genitals is conducted or circumstances when staff feel that it is appropriate. None of the forementioned criteria applied to these four physical examinations.
Deliverables	NO DATA

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Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	2.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	23.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	12.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	9.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	22.00
Number of sick call encounters where the reason is documented in the "Reason" field.	25.00
Number of sick call encounters where the reason for the visit was from an approved category.	24.00
Number of sick call encounters addressed by a nurse.	25.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25.00
Findings	NO DATA
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	N/A - See findings below.
Findings	No findings. Nursing Sick Call was found to be appropriate and IHSC nursing guidelines were used appropriately.
Deliverables	NO DATA

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	9.00
Number of MHU 23 hour observation records with discharge encounters.	9.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	9.00
Number of MHU 23 hour observation records with telephone order admission.	2.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	2.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	Overall good documentation only finding is that "Observation" was not labeled under reason of encounter.
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	NO DATA
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	0.00
Number of MHU full admission records reviewed.	25.00
Number of MHU full admission records with admission encounters.	25.00
Number of MHU full admission records with discharge encounters.	22.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	25.00
Number of MHU full admission records with no PE within the past year.	21.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	3.00
Number of MHU full admission records with acuity level assigned.	7.00
Number of MHU full admission records with all medications placed on pill line.	25.00
Number of MHU full admission records with 24 hour chart reviews everyday.	25.00
Number of MHU full admission records for patients in segregation for medical overflow.	0.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0.00
Number of MHU full admission records with a nursing care plan.	23.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	23.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	25.00

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Number of MHU full admission records with mental health diagnoses.	3.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	3.00
Number of MHU full admission records without mental health diagnoses.	22.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00

Findings

1) Best Practice Recommendation: (b)(5)

(b)(5)

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(b)(5)

Deliverables	NO DATA

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	11.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	10.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	11.00
Number of suicide watch records where the need for finger foos was annotated.	11.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	11.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	10.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	10.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	11.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	11.00
Findings	This reviewer only found 11 charts per eBO report. One detainee was sent to the hospital a few hours after being placed on watch. Therefore, findings that are 10/11 are not negative findings.
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	1.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	1.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	1.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	1.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	1.00
Findings	No findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Hunger Strike - Review Complete

Number of hunger strike records reviewed.	0.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	0.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	0.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	0.00
Number of hunger strike records with special needs.	0.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	0.00
Findings	No hunger strikes in the past 6 months
Deliverables	NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	19.00
Number of segregation records that indicate the patient was medically cleared for segregation.	19.00
Number of segregation records where daily segregation rounds by nursing are documented.	19.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	19.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	0.00
Number of segregation records where the patient was seen weekly by mental health.	11.00
Findings	1) Only 11 seg records noted to have been seen weekly by Mental health because for the remainder records the detainee was released from Seg prior to completing 1 week in seg.
Deliverables	NO DATA

AMERICAN OVERSIGHT

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	6.00
Number of after hours medication records with the patient's identification number documented.	6.00
Number of after hours medication records with medication order(s) documented in eCW.	3.00
Number of after hours medication records that were generated by a nurse as a telephone order.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	0.00
Does the pharmacy have a reconciliation process?	No - See findings below.
Does the pharmacy follow the reconciliation process?	No - See findings below.
Findings	There does not appear to be any clearly stated and understood process for the after hours cart usage and reconciliation of orders.
Deliverables	NO DATA

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	No - See findings below.
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No - See findings below.
Are after hours medication orders documented as dispensed in eCW?	No - See findings below.
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	There is no line entries for time, states how many meds are removed but not how many are left. A#s are used but rarely names.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	25.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	25.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	0.00
Reasons for why a translator was not used.	Out of the 25 charts review, no translator was used for any. Reasons: 1. "Provider fluent in patient's native language." 2. "Not applicable, patient speaks English." Out of the 25 charts reviewed, on one chart, the person conducting the intake screening incorrectly documented that an interpreter had been used. They documented themself as the interpreter. Since they did not seek the use of the language line or a colleague to interpret, I counted this chart as no interpreter used.
Findings	NO DATA
Deliverables	NO DATA

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	3.00
Number of refridgerator temperature logs that are up to date.	1.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	N/A - See findings below.
Findings	Refridgerator checks in pharmacy not done from Feb- June, July record missing. No weekend checks Freezer in pharmacy: July record missing, not done on weekends. Narc/Sharp log in Pill line room is combined would recommend these be two separate logs.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	12.00
Number of daily assignment sheets completed and archived .	12.00
Number of daily assignment sheets with one emergency team identified per shift.	12.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	12.00
Number of daily assignment sheets with clinic inspection completed and signed.	0.00
Are detainee referrals documented?	Yes
Findings	Call outs and leave not on assignment sheet. Clinic inspection is done by HSA and is kept separate, not done on weekends or holidays
Deliverables	NO DATA

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	0.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	0.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	0.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	0.00
Findings	Last monthly staff meeting was March. Site has not done local PHSP or QI meetings HSA has weekly meetings with ICE but does not take meeting minutes, will start this week. Site is going to start mandatory meetings immediately to include minute keeping.
Deliverables	NO DATA

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Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	20.00
Number of federal civil service employee personnel files reviewed.	1.00
Number of contractor personnel files reviewed.	14.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	N/A - See findings below.
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	5.00
Of the personnel file records for priveleged staff, how many are current?	5.00
Number of personnel files with current and signed Health and Ability form.	20.00
Number of personnel files with a signed statement of confidentiality (one time).	20.00
Number of personnel files with a signed statement of risks and responsibility (one time).	20.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	20.00
Number of personnel files with a signed release of information form (one time).	20.00
Findings	No findings
Deliverables	NO DATA

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Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	5.00
Number of federal civil service employee credentialing files reviewed.	1.00
Number of contractor credentialing files reviewed.	14.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	20.00
Number of credentialing files with current, valid, and unrestricted license.	20.00
Number of credentialing files with license primary source verification.	20.00
Number of credentialing files with documentation of primary education.	0.00
Number of credentialing files with education primary source verification.	0.00
Number of credentialing files reviewed for physicians or psychiatrists.	2.00
Number of physician or psychiatrist credentialing files with documentation of residency.	2.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	2.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	2.00
Number of credentialing files with a curriculum vitae or resume.	20.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	5.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	8.00
Number of credentialing files with scope of practice.	20.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	0.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	20.00
Number of peer reviews reviewed.	20.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	20.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	NO DATA
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	15.00
Number of employee health files with current TB (PPD or CXR) documentation.	15.00
Number of employee health files with current Hepatitis B vaccination or declination form.	15.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	14.00
Number of employee health files with current respirator medical clearance.	15.00
Number of employee health files with current respirator fit test.	15.00
Number of employee health files with emergency contacts.	0.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	N/A - See findings below.
Findings	Emergency contacts are kept in the Personal folders 14 of 15 employees needed Ishihara test, all had them. Three that did not were administrative
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	20.00
Number of training folders with HSD-500.	20.00
Number of training folders with a signed position description.	20.00
Number of registered nurse training folders reviewed.	10.00
Number of registered nurse training folders with RN Physical Exam Training.	10.00
Number of training folders with continuing medical education credits.	0.00
Number of training folders with BLS for health care providers or CPR and AED certification.	10.00
Number of radiation safetoy officer training folders with radiation safety training.	2.00
Findings	NO DATA
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Level

Facility: Port Isabel **Reviewers** (b)(6); (b)(7)(C) Dates: 4/9/18-4/12/18

IHSC Health Systems Assessment

Facility Overview

Months: Jan/Feb/March **Bed Capacity:** 1200 **MHU Beds:** 32

Daily Census: 107 0 **Male:** 1000 **Female:** 70 **Juveniles:** N/A **LOS:** 10 days

Average Number of Encounters					
Category	**Month 1**	**Month 2**	**Month 3**	**Average**	**% pop**
Pre-screening	1656	2113	3135	2301	
Intake	1597	1818	2627	2014	
Physical Exams	1021	726	671	806	
Vitals/Labs	607	737	541	628	
Sick call	1328	1035	1113	1158	
Pros/Imm	961	1012	571	848	
Acute	434	290	327	350	
Chronic	90	74	111	92	
Mental Health	417	310	404	1131	
Dental	105	94	109	103	
Emergent/Urgent	120	99	111	110	
MHU	2564	3171	2720	2818	
Seg	115	51	94	87	
Admin	64	44	23	44	
Transfers	1812	1962	2735	2170	
Totals					
Pill-line passes	19014	18885	21451	19783	
RX (Pill-line + KOP)	2849	2867	3070	2929	
Referrals / ER	108/18	89/20	115/21	104/20	

Staffing

(b)(7)(E)

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Facility: **Reviewers:** Dates:

PRE-ARRIVAL REVIEW

Accreditation

Reviewer: (b)(6); (b)(7)(C)

Most recent ACA, NCCHC, and PBNDS surveys. List type of survey and care

Survey	Date	Findings / Recommendations
ACA	May 2017	100% no findings
PBNDS	Feb 2018	No findings
NCCHC	May 9, 2016	HSA was not at facility at that time and was not sure if there were any findings
Comments		

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Facility:	**Reviewers:**	Dates:

Grievances

Reviewer (b)(6); (b)(7)(C)

Evaluation Method:	**Observation**	
Items to Review *(review 100% during past year)*	**Yes, No, or N/A**	**Comments**
1. Have there been any medical grievances reported through QI/JIC/CRCL/DRIL * (*if so, provide type in comment section)*	No	
2. Is there a local procedure (SOP) for managing grievances?	No	*Follow National Policy*
3. Is there an identified grievance officer?	*Yes*	(b)(6); (b)(7)(C)
4. Is the log book kept and up to date?	*Y*	
5. Were all Grievances addressed in a timely manner?	*Y*	
6. Number of Formal/Informal grievances:_____1_____/____1_____		

Findings/ Recommendations:	**None**
Deliverables:	**None**

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Facility:	Reviewers:	Dates:

Incident Reports/RCA/SOE

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:			
Items to Review *(review 100% during past year)*		**Yes, No, or N/A**	**Comments**
1. Were there any trends noted from reported incident reports or RCAs for FY17?		No	
2. Are there any active RCAs/SOE?		No	
3. Has a RCA or SOE been completed during this FY? If so, complete #4		No	
4. Was a CAP initiated and/or completed for the RCA or SOE?		No	
a. If CAP initiated, note status and due date.			
Findings/ Recommendations:			
Deliverables:			

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Facility:	Reviewers:	Dates:

On-Site Observations

During site observations, the reviewers should observe staff members carrying out the task, interview staff, review medical records and review supporting documents (i.e. logs, minutes, binders, electronic trackers, etc.).

Medication Administration (Observations-On site Review)

Question (10 ENCOUNTERS)	Improvement Plan (1,2, or 3)	Comments
Is pre-pouring occurring? **(Be sure to observe more than one nurse on multiple shifts)** **Level 2@100%**	No	
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)? **Level 2 @100%**	Yes	
Are mouth checks being conducted with every administration? Observe 10 patients (if possible) on multiple shifts **Level 1 @80%**	Yes	
Are all entries in the MAR complete (allergies, staff initials, etc.)? Observe 10 different MAR; **Level 1 @80%**	Yes	
Are nurses documenting the medication administration immediately after the medication is administered**? Level 2 @100%**	Yes	
Number of all medication refusals documented on the MAR/eMAR **Denominator**	6	

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Facility: **Reviewers:** Dates:

Of the identified medication refusals from the MAR, how many refusals did have an accompanying signed refusal form? **Level 2@90%** .	Yes	
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal in eCW **Level 1 @100%; See guide eon ECW notification**	Yes, all refusals identified were psch meds and had Telephone encounter sent to provider.	

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Facility: **Reviewers:** Dates:

Emergency Preparedness and Response

Question	Improvement Plan (1,2, or 3)	Comments
Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)? Refer to guide : **level 1 @90%** Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)? Refer to guide **level 1 @90%** Is there documentation showing completed date and time of mass casualty drills * (each shift should have a complete drill within a three year period)? *Table top/mock drills are acceptable replacements for drills not conducted facility wide Refer to guide: **level 1 @90%** Are clinic staff trained on emergency equipment (AED, first Aid kits, fire extinguisher, etc?) Yes/No **level 1 @90%**	Yes Yes Yes Yes	
Do emergency scenarios vary? Yes/No?? **Level 100 % if No**	Yes	
Is the difference between a drill and an actual event evident in the write-up?): **Level 1 @100%**	Yes	All were drills
Is there process in place to distribute "an after-action report to all staff**?** **Level 1 @90%:**	Yes	
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event? **Level 1 @100%**	Yes	
Comments:		
Deliverables: None		

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Facility:	Reviewers:	Dates:

Consent Forms

	Section Completed Under the Pre-Audit Chart Reviews		
	Question	**Improvement Plan Levels (1,2, or 3)**	**Comments**
	1. Number of consent forms (General consent) that were complete (not missing detainee signature, witness, or date). **Level 1 @100%:** Can escalate to Level 2 if not resolved by the completion of the assessment	0	
	2. Number of dental consent forms among the identified consent forms.	5	
	3. Number of dental consent forms that were complete (missing detainee signature, witness, or date) **Level 1 @90%**	0	
	4. Number of psychotropic consent forms among the identified consent forms.	9	
	5. Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date) **(Level 1 @90%)**	0	
Findings/ Recommendations:	Consent forms were completed in the pre-audit Chart Reviews		
Deliverables:	None		

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DHS-ICE-20-0618-A-000383

Facility: **Reviewers:** Dates:

Transfers

Reviewer

Evaluation Method:	Section Completed Under the Pre-Audit Chart Reviews	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of outgoing transfers authenticated appropriately (signed, stamped, and dated): **Level 1 @100%**	24	Out of 25, one was not authenticated appropriately
2. Number of outgoing transfers completed by LVN or above. **Level 1 @100%,**	25	
3. Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility) Level 2 @90%	25	
4. Of the 25 transfers reviewed for TB clearance documentation, how many correctly documented no TB treatment status? **see guide Level 2@90%**	18	Transfer summaries reviewed showed documentation of negative CXR and no treatment even with positive CXR and TB meds. 72%
5. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented no TB treatment status? see guide **Level 2@90%**	9	Two were out of compliance- 92%
6. Of the 25 transfers reviewed for TB clearance documentation, how many - correctly documented TB treatment status? see guide: **Level 2@90%**	25	
7. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented TB treatment status? see guide: **Level 2@90%**	0	

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Facility:	Reviewers:	Dates:

Findings/ Recommendations:	Pre audit showed transfer summaries not showing correct data with regards to detainees with positive Chest x-rays and treatments.
Deliverables:	Transfer summaries regarding detainees with TB. Incorrect information is being put on or correct information is omitted.

Pre-Screening

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	**Observe 10 pre-screens if Possible**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of prescreen encounters observed. **Denominator**	*15*	
2. Are language services being used during pre-screen if appropriate? **Level 2: if No**	*0*	All detainees were Spanish speaking/ nurses I observed all spoke Spanish fluently.
3. Number of prescreens with documentation completed in eCW prior to intake screening. **Denominator**	*15*	
4. Number of prescreen encounters prioritized. **Level 1: @90%**	*1*	Detainee had HTN and diabetes
5. Number of Pre-screens encounters not prioritized appropriately: **Level 1 @90%**	*0*	
Findings/ Recommendations:	None	

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Facility:	Reviewers:	Dates:

Intake Screening

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observe 10 "Intakes" if Possible

Items to Review *(review 25 records in the past month)*	Improvement Plan Levels (1,2, or 3)	Comments
1. Number of intake screenings observed. (N/A) **Denominator**	*8*	
2. Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening. **Level 1 @90%**	*8*	
3. Number of intake screening observations where a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat were taken. **Level 2: @90%**	*8*	
4. Number of intake screening observations that used language services. **Level 2:@90%**	*0*	All detainees spoke Spanish, all nurses were fluent in Spanish
5. Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)? **Level 1 @90%**	*8*	
6. Of the intake screening observations that used language services, how many were appropriately conducted? **Level 2:@90%**	*N/A*	
7. Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide. **Level 2:@90%**	*8*	

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8. Number of intake screening observations with security advice of special needs and housing disposition. **Level 1 @90%**	*8*	
Finding/Recommendations	None	
Deliverables:	None	

AMERICAN OVERSIGHT

Facility:	Reviewers:	Dates:

Chronic Care

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observe 10 "Chronic Care Encounters"		
Questions		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of chronic care encounters observed that utilized language services appropriately. **Level 2 @90%**		*5*	5 out of 5 observed
2. Number of chronic care encounters observed that were completed within the time frame indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit **Level 2 @90%**		*5*	5 out of 5 observed
3. Number of chronic care encounters observed that were not completed within the timeframe indicated by a previous visit (greater than 90 days for unstable patients). **Level 2 @90%**		*5*	5 out of 5 observed
Findings/ Recommendations:	No issues were found on site, but pre audit showed providers were not consistently putting in global alert.		
Deliverables:			

AMERICAN OVERSIGHT

Facility:	Reviewers:	Dates:

Physical Exams

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observe 10 physical exams completed by different providers	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of physical examination encounters with a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken **Level 2@90%**	*5*	5 out of 5 observed
2. Number of physical examination encounters observed that were completed within the specified timeframe. (Two Business days for PE-Cs , 7days for –juveniles and , 14-days for adults) **Level 2@90%**	*5*	5 out of 5 observed
3. Number of physical examination encounters observed that offered detainee provider referral when appropriate **Level 1 @90%**	*5*	5 out of 5 observed
Findings/ Recommendations:	None	
Deliverables:	None	

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000389

Facility:	Reviewers:	Dates:

Sick Call

Reviewer (b)(6); (b)(7)(C)

Evaluation Method:	Observation

Items to Review *(Observe 10 "Sick Call "Encounters if possible)*	Improvement Plan Levels (1,2, or 3)	Comments
1. Is sick call offered face-to-face on a daily basis?? **Level 1 if NO**	*Yes*	**Detainees sign up in dorms, everyone on sign up sheets is brought to clinic.**
2. Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented) **Level 1; if NO**	*Yes*	**Starts at 0700, runs until completed**
3. Is translator services offered when appropriate during a sick call process? **Level 1; if NO**	*Yes*	**Observed nurse using translator services**
4. Did RN utilize nursing protocols/guidelines during sick call encounters?	*Yes*	**Used while on site, but in pre-audit not always referenced.**
5. Is a guardian present for any minor (<18 years of age) sick call? **Level 1; if NO and applicable**	*N/A*	
6. Is there a sick call log used to document all encounters?	Yes	**Binder kept with all sick call sign up sheets**

Findings/ Recommendations:	None on site. Pre audit showed RN's were not consistently referring to provider after the third complaint or referencing nursing guidelines.
Deliverables:	

AMERICAN OVERSIGHT

Facility:	Reviewers:	Dates:

Medical Housing Unit 23hr Observation

Reviewer:

Evaluation Method:	Not Applicable at site. No resident at 23-hour observation	
Items to Review *(Observe 10 MHU 23-HR OBS if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU 23 hour observation records reviewed. **Denominator**	0	*No detainees were under 23 hour observation.*
2. Number of MHU 23 hour observation records with documentation regarding return to general population		
3. Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis documented on placement in the medical housing unit		
4. Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 2 business day. **Level 1: @80%**		
Findings/ Recommendations:		
Deliverables:		

AMERICAN OVERSIGHT

Facility:	Reviewers:	Dates:

Medical Housing Unit full Admission Observation

Reviewer:

Evaluation Method:	Observation		
Items to Review *(10 detainees if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are all patients within sight or hearing of a qualified health professional? **Yes/No**??		YES	
2. Number of nurses in the MHU at time of observation **(Denominator)**		2	
3. Number of patients in the MHU at time of observation		17	
4. Number of MHU full admission records with 24 hour chart reviews every day. (Review one 24-hour chart in detail to confirm review was done appropriately) **Level 1: @90%**		4	REVIEWED 10 CHARTS, SIX DID NOT HAVE 24 HOUR CHART CHECKS WITHIN THE LAST TWO DAYS.
5. Number of MHU full admission records with all medications (except KOP med exceptions see guide) placed on pill line. **Level 2 @90%**		10	
Findings/ Recommendations:	24 hour chart checks were not being done consistently. Of the 10 charts reviewed six did not have the required nursing chart check documented. Pre-Audit showed detainees without mental health diagnosis were not receiving 30 day mental health exams.		
Deliverables:	(b)(5)		

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000392

Facility:	Reviewers:	Dates:

Suicide Watch- Observations

Reviewer:

Evaluation Method:	None observed on Site		
Items to Review *(Observe 10 detainees on "suicide watch "if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of patients on suicide watch **Denominator**		*1*	Detainee was on constant watch, not suicide
2. Number of patients on suicide watch with nursing assessment performed within the past 8 hours. **Level 3 @ 100%**		*1*	
3. Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule. **Level 3@ 100%.**		*1*	
4. Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours. **Level 3 @ 100%.**		*1*	
5. Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc). **Level 3@ 100%**		*N/A*	Detainee was on constant watch, not suicide
Findings/ Recommendations:	Pre audit showed one detainee did not have the appropriate suicide risk assessment form completed within 24 hours of referral.		
Deliverables:			

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000393

Facility:	Reviewers:	Dates:

Hunger Strike -Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees on "Hunger Strike" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Was water available to detainees on hunger strike? **Level 3: if NO @90%**		*N/A*	**No detainee on hunger strike.**
2. Were meals (if observed during meal times) offered to patient and how MUCH OF THE of the food SERVED was eaten **Level 3: If NO @90%**			
3. Of the hunger strike records with special needs, how many records indicate that the needs were addressed? **Level 3 @90%**			
Findings/ Recommendations:	None		
Deliverables:	none		

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000394

Facility:	Reviewers:	Dates:

Segregation- Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees in "Segregation" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU full admission records for patients in segregation for medical overflow. **(Denominator)**			Not applicable, medical did not have any detainees housed in segregation unit.
2. Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on every 8 hours according to MHU policy **Level 3 @90%**			
3. Was sick call offered to detainees in segregation or other specialty housing units? **Level 2 @90%**			
Findings/ Recommendations:	Pre-Audit- found four of 25 seg detainees did not have a daily segregation round by a nurse (not medical segregation).		
Deliverables:			

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000395

Facility:	Reviewers:	Dates:

After-Hours Medication (night pharmacy)

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of after-hours medication log records reviewed. **(Denominator)**	*10*	
2. Number of after-hours medication LOG records that were generated by a nurse as a telephone order. **Level 2 @90%**	*4/4*	Of the two pages of "After Hours medication only four were checked out by a nurse, rest were signed out by the APP
3. Number of afterhours medication records that were generated by a nurse as a telephone order and were signed by a provider within 24 hours returning for next work shift **Level 2 @90%**	*Y*	
4. Does the pharmacy have a reconciliation process? **; Level 2 if NO @90%**	*Y*	
5. Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed from the AHC: **Level 1 @100%**	*Y*	
6. Is all necessary information entered into the fields of the After-Hours Cabinet (AHC) sign out log. **Level 1 @100%**	*Y*	

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7. Is a medication log in place and reflective of quantities of medication stored in the night cabinet? **(Level 1 if NO)**	*Y*	
8. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed? **Level 2 @100%: if NO**	*Name and A number were combined and only A number was being used as not enough space for both. Time was not on log.*	*This form was corrected to include a box for time and name and A number separated.*
9. Is the after-hours verbal medication order entered into eCW by the prescriber upon return to duty? **Level 2@100%**	*Yes*	
10. Is the after-hours medication administration properly documented on the MAR or in the electronic health record? **Level 2@100%**	*Yes*	
11. Is the night cabinet, clean, stocked, and organized?	*Yes*	
12. Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications? **Level 2 @100%**	*Yes*	

Findings/ Recommendations	(b)(5)
Deliverables:	New log was created while we were on site with the above corrections.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000397

Facility:	Reviewers:	Dates:

Language Access- Observations

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	*Yes*	
2. Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities? **If No; level 2; @100%**	*Yes*	
Findings/ Recommendations:	None	
Deliverables:	None	

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000398

Facility:	Reviewers:	Dates:

Diagnostic Services

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are laboratory services provided in adherence with CLIA Waived testing? **Level 3: @90%**	*Yes*	
2. Is there a current certificate for CLIA-waived testing: **Level 2@100%: CLIA services stopped until obtained.**	*Yes*	
3. Are radiation signs posted on all doors leading to areas with radiation producing equipment? **Level 1 @100%, "SPOT-FIX, May escalate to Tier 2 If multiple rooms noted not addressed by the end of the visit**	*Yes*	
4. Are Dosimetry reports reviewed quarterly (MONTHLY FOR DECLARED PREGNACIES) by the Compliance officer or HSA? (Yes/No): **If No level 2@100%**	*Yes*	
5. Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment? **Level 2@100%**	*Yes*	

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6. Are staff dosimeter badges and controls stored in a central location and not near a radioactive source? **Level 2@ 100%**	*Yes*	
Findings/ Recommendations:	None	
Deliverables:	None	

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Facility:	Reviewers:	Dates:

Log Books

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of pharmacy refrigerator temperature logs reviewed **(Denominator)**	*6*	
2. Number of pharmacy refrigerator temperature logs that have entries per shift for the past three months. **Level 1 @90%**	4	*Entries are done daily, not per shift. Pharmacy not checking temperatures on the weekends. Have correct thermometers to go back on Monday and check temperature ranges. State they will put in place.*
3. Number of refrigerator temperature logs that are out of range. **(Denominator)**	*0*	
4. Of the refrigerator temperature logs that are out of range, how many logs have documentation of action taken and follow-up ?(**Level 1 @90%)**		
Are the sharps secured and count accurate? **Level 2 @100%, if NO**	*Y*	
In review of the past 3 months of sharps counts, are two signatures present for each shift changes? (**Level 1 @90%)**	*Y*	
Are the narcotics secured, (double locked) and counts within the last 3 months accurate (clinic and pharmacy supply)? **Level 3 @90%**	*Y*	
In review of 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts? **Level 1 @90%**	*Y*	

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Are the urgent care cart/trauma bag and AEDS checked daily for content (signatures, AED functionality, and expiration for the past 3 months? **Level 2 @90%**	*Y*	
Findings/ Recommendations:	**When Sharps and Narcotics are being signed out nurses are not documenting A numbers, only names that are mostly illegible. Would be very hard to go back and reconcile if needed. Change forms to include A number and name. Document legibly.**	
Deliverables	Pharmacy has thermometers on site where they can go back on Monday and check the temperatures from previous days. They are going to install them in their refrigerators and train pharmacy staff on how to use.	

Daily Assignment Sheet (DAS)

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observation	
Items to Review *(review 10 random days)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of daily assignment sheets reviewed per month) **Denominator**	*30*	
2. Number of daily assignment sheets that were archived appropriately.	*30*	*No IP level; Observation only for 2018 audits*
3. Number of daily assignment sheets reviewed had at least one emergency team identified per shift. **Level 1 @90%**	*28*	Two out of 30 Daily Assignment sheets reviewed did not have emergency teams identified.
Findings/ Recommendations:	See above	
Deliverables:	None	

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Facility:	Reviewers:	Dates:

Shift Report and Time-cards

Reviewer:

Evaluation Method:	Observation		
Items to Review *(audit 10 random cards)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are shift reports conducted?		*Yes*	*No IP level: best practice*
2. Is there at least one representative from each department?		*Yes*	*No IP level: best practice*
3. Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?		*Yes*	*No IP level Observation only for 2018 audits*
Findings/ Recommendations:	None		
Deliverables:	None		

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DHS-ICE-20-0618-A-000403

Facility:	Reviewers:	Dates:

Meetings

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the two previous staff meetings, how many were conducted monthly and properly documented? **Level 1 @80%**		*0*	**Monthly staff meeting are not be conducted**
2. Out of the two previous public health, safety, and preparedness meetings, how many were properly documented? (**Level 1 @80%)**		*2*	*January 26th* *April 4th*
3. Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented? **(Level 1 @80%)**		*2*	*October 10th* *March 23rd*
4. Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented. **Level 1 @80%**		*2*	*Bi weekly on Wednesday*
Findings/ Recommendations:	**Monthly staff meetings are not being conducted.**		
Deliverables:	HSA to start monthly staff meetings in May 2018		

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Facility:	Reviewers:	Dates:

PERSONNEL

Personnel and Credentialing Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files each if available*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the 12 personnel and credentialing files reviewed how many were PHS officers **No IP level**	*2*	
2. Of the 12 personnel and credentialing files reviewed how many were federal civil service employee **No IP level**	*1*	
3.Of the 12 personnel and credentialing files reviewed how many were contractors	*9*	
4. Does the facility have a process for tracking requirements electronically?: **No IP level**	*Yes*	
5. Of the 12 personnel and credentialing files reviewed how many records are for privileged staff (physician, psychiatrist, psychologist, dentist, and social worker)?: **No IP level**	*5*	5 of the 12 personnel files reviewed were LIP employees.
6. Of the 12 Privileged staff that are Licensed Independent Practitioners (LIPs) how many had current personnel files records current? (Yes/No) **Level 2@100%**	*5*	
7. Of the 12 personnel files reviewed, how many contained a current and signed Health and Ability form? **Level 1 @90%**	*12*	
8.Of the 12 personnel files reviewed, how many contained a signed statement of	*12*	

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confidentiality (one –time statement signed by staff) **Level 1; @90%**		
9. Of the 12 personnel files reviewed, how many contained a signed statement of risks and responsibility (one time)?	*12*	
10. Of the 12 personnel files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time). **Level 1; @90%**	*12*	
11. Of the 12 personnel files reviewed how many contained a signed release of information form (one time). **Level 1; @90%**	*12*	
13.Of the 12 credentialing files reviewed, how many contained current, valid, and unrestricted license **Level 3: if not 100%**	*12*	
14. Of the 12 credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification **Level 1 @90%**	*12*	
15. Of the 12 credentialing files reviewed how many were reviewed for physicians or psychiatrists.	*1*	
16. Of the 12 credentialing files reviewed for physician or psychiatrist how many had documentation of residency. **Level 2@90%**	*1*	
17. Of the 12 credentialing files reviewed how many board certified physician or psychiatrist had documentation of board certification. **Level 2 @90%**	*1*	
18. Of the 12 credentialing files reviewed how many had a copy of a curriculum vitae or a resume. **Level 1 @90%**	*12*	

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15. Of the 12 credentialing files reviewed how many PHS officers had at least two years of evaluations (COERS). **Level 1 @90%**	*2*	
19. Of the 12 credentialing files reviewed how many had current National Provider Data Bank information. (renewable every 2 years) **No IP level**	*5*	Per (b)(6); (b)(7)(C) only LIPs need NPDBs and it should be yearly.
20. Of the 12 credentialing files reviewed how many had scope of practice documentation(Pertinent staff only)**Level 1 @90%**	*7*	100% of pertinent staff had scope of practice.
21. Of the 12 credentialing files reviewed for LIPs how many had a competency assessment or peer review. **Level 2 @90%**	*5*	100% of LIPs
22. Of the 12 personnel files reviewed, how many contained training folders with HSD-500 record. **No IP level**	*12*	
23. Of the 12 personnel files reviewed, how many contained training folders with a signed position description. **No IP level**	*12*	*No IP level Observation only for 2018 audits*
24. Of the 12 personnel files reviewed, how many contained registered nurse training folders reviewed. **No IP level**	*4*	*No IP level Observation only for 2018 audits*
25. Of the RN personnel files reviewed, how many contained registered nurse training folders with RN Physical Exam Training. **No IP level**	*4*	**4 out of 4**
26. Of the 12 personnel files reviewed, how many contained continuing medical education credits. **No IP level**	*6*	
27. Of the 12 personnel files reviewed, how many contained BLS for health care providers or CPR and AED certification. **Level 1 @90%**	*12*	

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Facility:	Reviewers:	Dates:

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DHS-ICE-20-0618-A-000408

Facility:	Reviewers:	Dates:

Employee Health Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are employee health files kept separate from other files? (Yes/ No) **No IP level**	*Yes*	
2. Is access to employee records limited to the compliance officer, HSA, and AHSA(s) and AA? **No IP level**	*Yes*	
3. Of the twelve employee health reviewed how many files had past year's TB (PPD or CXR) documentation. **No IP level**	*12*	
4. Of the twelve employee health reviewed how many files had Hepatitis B vaccination or declination form. **No IP level**	*12*	*No IP level Observation only for 2018 audits*
5. Of the twelve employee health reviewed how many files had yearly Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing). **Level 1 @80%**	*12*	*Ishihara color blind documentation was being kept under the competencies in the Personnel files. Told staff to create tab in health files and move.*
6. Of the twelve employee health reviewed how many files had yearly respirator medical clearance**. Level 1 @80%**	*0*	*Yearly respirator medical clearance forms were not being completed on the employees.*
7. Of the twelve employee health reviewed how many files had yearly respirator fit test. **Level 1 @80%**	*12*	
8. Of the twelve employee health reviewed how many files had with emergency contacts.	*12*	
9. Are staff injuries and illnesses documented on the Workforce Injury Tool? **Level 2 @90%**	Yes	

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Facility:	Reviewers:	Dates:

Findings/ Recommendations:	**Yearly respirator medical clearances not being done.**
Deliverables:	(b)(5)

Training

Reviewer: CDR McMahan

Evaluation Method:	Observation		
Items to Review *(Review 12 Files)* ***No IP level****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the twelve training folders reviewed how many had documentation of completed Mandatory ICE Trainings (see guide for list of trainings)		*12*	*2017 training reviewed*
2. Of the twelve training folders reviewed how many had documentation of completed IHSC Mandatory Trainings(see guide for list of trainings)		*12*	
3. Of the twelve training folders reviewed how many had documentation of Completed Emergency preparedness Trainings(see guide for list of trainings)		*12*	
4. Of the twelve training folders reviewed how many had documentation of completed Occupational Health Trainings (see guide for list of trainings)		*12*	

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5. Of the twelve training folders reviewed how many had documentation of completed TB Management Trainings	*12*	
6. Of the twelve training folders reviewed how many had documentation of completed Mental Health Training for Behavioral Health Providers (see guide for list of trainings)	*12*	
Findings/ Recommendations:	*All training was completed but recommend a more organized system. Training was kept in several different areas and difficult to find for an auditor.* (b)(5) (b)(5)	
Deliverables:		

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Facility:	Reviewers:	Dates:

Schedules

Reviewer: (b)(6); (b)(7)(C)

Evaluation Method:	Observation		
Items to Review *(Review 3 months Schedules)* *****No IP levels*****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the three month schedules reviewed, how many had a legend to explain codes.		*Yes*	
2. Out of the three month schedules reviewed, how many had staff assigned 40 HRS PER WEEK20" per scheduling period.(Refer to guide)		*Yes*	
3. Out of the three month schedules reviewed, how many had provider coverage on weekend/holidays.		*Yes*	
4. Out of the three month schedules reviewed, how many had actual work hours reflected for non-traditional shifts.		*No*	
5. Out of the three month schedules reviewed, how many had signed approvals for non-traditional shifts?		*N/A*	
6. Out of the three month schedules reviewed, how many had a PDF copy each time a change was made to the schedule?		*Yes*	
Findings/ Recommendations:	None		
Deliverables:	None		

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DHS-ICE-20-0618-A-000412

Facility:	Reviewers:	Dates:

Summary

Topic	Findings/Recommendation
Chronic Care	Providers not consistently putting global alerts on these detainees.
Sick Call	Refer detainee to APP after third sick call of same complaint, Always reference nursing guideline in sick call note that you are using
MHU	24 hour chart checks not being done consistently. 6 of the 10 record reviews did not have them.
MHU	Detainees in MHU for over 30 days were not being seen by BHP.
SHU	4 out of 25 segregation detainees did not have daily nursing notes
Pharmacy Refrigerator Checks	Pharmacy not doing temperature checks on weekend or holidays to ensure temperature did not go out of range
Meetings	Monthly staff meetings not being conducted
Employee medical files	Yearly Respirator medical clearance forms not being completed
Training files	Very unorganized, recommend each employee has own file plus create a spreadsheet to keep track of training.
Transfer summaries	Documentation regarding TB treatment and x-ray results are not consistently correct on forms

Recommendations from Facility

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Facility:	**Reviewers:**	Dates:

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Facility:	Reviewers:	Dates:

Additional Comments *(include Section and item number)*

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Deliverables

Topic	Items	Due	Lead
MHU	24 hour chart checks	5/29/2018	(b)(6); (b)(7)(C)
Pharmacy Refrigerator	Site stated they had correct thermometers on site and would set them up. Follow up to ensure they did.	Completed on site	(b)(6); (b)(7)(C)
Meetings	Monthly staff meetings not being conducted, follow up with site to ensure they started in May.	5/29/2018	
Employee medical file	Yearly respiratory medical clearances were not being done. Program Manager given information on how to complete, follow up to ensure all employees completed.	5/29/2018	
Transfer Summaries	Transfer summaries for detainees with TB are not being completed correctly.	6/15/2018	

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Unit Chiefs and Leadership Review Comment & Feedback

Leadership	Recommendations/ Comments/ Feedback
Chief of Health Operations	
Chief Advance Practice Practitioner	
Chief of PHSP	
Chief of Nursing Services Unit	
Chief OF Medical Quality Management Unit	
DAD-Health Systems Support	
DAD Healthcare Compliance	
DAD Clinical Services Review	
Chief Medical Officer Review	
Chief of Staff Review	
AD, IHSC Review	

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Facility:	**Reviewers:**	Dates:

Chief of Health Operations _____

Signature

Chief Advance Practice Practitioner _____

Signature

Chief of Public Health Safety and Preparedness Unit _____

Signature

Chief of Nursing Services Unit _____

Signature

Chief Medical Quality Management Unit _____

Signature

Leadership Signatures

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Facility:	Reviewers:	Dates:

DAD-Health Systems Support

_____

Signature

DAD Healthcare Compliance

_____

Signature

DAD Clinical Services Review

_____

Signature

Chief Medical Officer Review

_____

Signature

Chief of Staff Review

_____

Signature

AD, IHSC Review Status

_____

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DHS-ICE-20-0618-A-000419

IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
Report generated: undefined
Report generated: undefined
Report generated: undefined
Report generated: undefined

Assessment Information - Report Complete

Facility	Port Isabel
Site visit start date	2019-04-22
Site visit end date	2019-04-26
Fiscal Year	FY2019
Fiscal Quarter	Q3
Post-audit corrective action identified	Yes
Immediate corrective action identified	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Complete
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Deferred (Team Lead Only)
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Review Deferred (Team Lead Only)

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1200
MHU Beds	38
Daily Adult Male Population	919
Daily Adult Female Population	70
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	14
Facility Information Comments	1-Nurse Manager, 1 Admin Assistant, 1 Contract Coordinator

Average Number of Encounters (Past 3 Months)

Prescreenings	2113
Intake Screenings	1488
Physical Examinations	431
Vitals/Labs	473
Sick Call	1502
Pros/Imm	823
Acute	306
Chronic	67
Mental Health	377
Dental	126
Emergent/Urgent	188
MHU	2347
Segregation	147
Admin	40
Transfers	1628
Pill-Line Passes	4261
Prescriptions (Pill-line + KOP)	1680
Referrals/ER	101

Accreditation - Review Complete

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Last ACA Accreditation	2017-06-05T04:00:00Z
Last ACA Findings	No data reported
Last NCCHC Accreditation	2016-06-06T04:00:00Z
Last NCCHC Findings	No data reported
Last PBNDS Accreditation	2019-01-29T05:00:00Z
Last PBNDS Findings	No data reported
Accreditation Comments	No data reported

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	10
Of the after hours med log records reviewed, how many records documented the patient's identification number?	10
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	7
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	7
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	NOTE: Only 7 ouf of 10 records had a TE generated from the nurse because the order was written by the APP on weekend or after pharmacy hours. Some APPs work 12 hour shifts so they are in-house for a few hours after pharmacy leaves.
After Hours Medication Chart Review Deliverables	None

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
	Yes

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Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	
After Hours Medication Encounters Findings	Identified as BEST PRACTICE! Cart is available in medical clinic after pharmacy hours however during pharmacy hours it is stored in the pharmacy. This eliminates the tempatation to use for convenience reasons during normal pharmacy operations.
After Hours Medication Encounters Deliverables	None

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	23
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	17
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	17
Of the chronic care records reviewed, how many detainees had psychiatric medications?	1
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	1
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	1
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	24
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	24
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	1
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	1
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	16
Chronic Care Records Findings	1) Of the 25 charts reviewed, 9 of the charts had Global alert documented as Medical Hold or disability (unsure why that was documented instead of Med/Psych alert); none of those 9 charts were TB cases which would account for the documentation of a medical hold. 2) Difficult identifying chronic follows appointments for

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	those with chronic mental health conditions on psych medications, it was identified that they are not being scheduled as chronic follow ups; assuming since this site has a Psych APP the monthly chronic follow up to review psych medication side effects are being completed as mental health appointments. I was only able to find one mental health on pysch medication detainee labeled as chronic appointment/follow up. 3) Kudos to the facility's RNs for identifying and referring detainees during the RN sick call who failed to report chronic conditions duirng intake.
Chronic Care Records Deliverables	1) Follow up with site to ascertain their understanding of Med/Psych alert vs. Medical Hold vs. Disability Global Alerts 2) Follow up with site to ascertain their process for documenting monthly chronic care follow up appointment for detainees with chronic mental health conditions on psych medications. (are they documenting them as Chronic F/U vs Mental Health encounter types)

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	9
Of chronic care encounters observed, how many were considered stable patients?	9
Of the stable patients observed, how many were completed within the appropriate timeframe?	9
Of chronic care encounters observed, how many were considered unstable patients?	0
Of the unstable patients observed, how many were completed within the appropriate timeframe?	0
Of the chronic care encounters observed, how many had a treatment plan?	9
Chronic Care Encounters Findings	No Global Alert concerns noted during observations as was noted with the Chronic Care Chart Review. Discussed with team and CD, Mental Health CH appointments. They have a new PMHNP who previously worked as FNP so they are still working with Chief Psychiatrist to best determine exactly her role within the clinic.
Chronic Care Encounters Deliverables	None

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	25
Of the general consent forms reviewed, how many were complete?	25
Of the consent forms reviewed, how many were dental consent forms?	11

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Of the dental consent forms reviewed, how many were complete?	11
Of the consent forms reviewed, how many were psychotropic consent forms?	13
Of the psychotropic consent forms reviewed, how many were complete?	13
Consent Forms Findings	No findings. All consent forms reviewed for dental procudres and psychotropic medications had appropiate consent forms.
Consent Forms Deliverables	No deliverables expected from site

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	6
Of the daily assignment sheets reviewed, how many were archived appropriately?	6
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	6
Daily Assignment Sheets Findings	Daily assignment sheets were updated on morning shift. However, evening shift numbers were not updated consistently. The NM corrected the currrent assignment shift sheet and reported that she would review evening assignments to ensure appropriate updates.
Daily Assignment Sheets Deliverables	Send three (3) random assignment sheets to RHSA for review from May 2019 and June 2019 by 1 JUL 2019.

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	No recommendations
Diagnostic Services Deliverables	No deliverables

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Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	No
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	1)There is documentation of man down drills, but no roster of attendance. It has been recommended that an attendance roster with signatures is completed. 2)Fire drills are completed per policy, but drill scenario locations are not varied. Recommend varied locations of fires reported in the drill. 3) Drills debrief minutes are not shared with the facility. Recommend sharing drills with staff in the facility and maintaining a signature roster of review for staff members that were not present. 4) Recommend saving pdf versions of staff drills and training rosters. 5) Recommend reviewing emergency response bag with the team when changes or updates are made.
Emergency Preparedness and Response Deliverables	1 JUL 2019-provide RHSA with documentation of drill rosters and meetings minutes from May 2019 and June 2019.

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	Yes
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes

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Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	(b)(5)
Environmental Health Deliverables	No deliverables

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	3
Is there a local SOP for managing grievances?	No
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	11
Number of informal grievances.	0
Grievances Findings	No recommendations
Grievances Deliverables	No deliverables

Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	0
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	0
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	0
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	0
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	0
	0

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Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	0
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	0
Hunger Strike Records Findings	No Hunger strike encounter found during chart review peroid
Hunger Strike Records Deliverables	None expected

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	0
Of the patients on a hunger strike, how many were offered meals?	0
Of the patients on a hunger strike who were offered food, how much food was offered?	N/A
Of the food offered, how much of the food was eaten?	N/A
Of the patients on a hunger strike, how many had special needs?	0
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	No detainees on Hunger Strike during site visit.
Hunger Strike Encounters Deliverables	None

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	No recommendations
Infectious Disease Prevention Deliverables	No deliverables

Intake Screen Chart Review - Review Complete

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How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	4
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	4
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	21
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	0
Of the records with a pain scale greater than 0, how many were assessed?	0
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	7
Of the intake records with clinically significant findings, how many were referred appropriately?	7
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	9
Intake Screen Records Findings	Out of the 25 intake screen records reviewed, 18 of them were completed by a LVN or LPN, thus requiring the review of a RN or higher within 24 hours. Out of those 18 intake screens completed by a LVN or LPN, nine (9) of them were reviewed by a RN or higher within 24 hours. Nine others did not meet that requirement. Out of the 25 intake screen records reviewed, one record suggested that a default drop-down option was not changed to reflect the patient's response. On one record, the detainee's language spoken was listed as English, perhaps the first default option in e-CW? However, the record clearly indicated that a Chinese translator was utilized during the Intake screening.
Intake Screen Records Deliverables	Refer to RCA for intake checks. No deliverables related to template updates. 1 JUL 2019-site will f/u with RM regarding RCA findings to include intake checks.

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	3
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	3

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Of the intake screen encounters observed, how many included a full set of vital signs?	3
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	3
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	3
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	3
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	3
Intake Screen Encounters Findings	Only 3 intakes observed due to intake arrived during night shift and were completed prior to start of day shift.
Intake Screen Encounters Deliverables	None

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	2
Of the language access records reviewed, how many did not use a translator?	23
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	23
Language Access Records Findings	None
Language Access Records Deliverables	None

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	No recommendations
Language Access Encounter Deliverables	No deliverables

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Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	6
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	6
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	No
Log Books Findings	Logs for urgent care trauma bag and crash cart do not have numbers for the lock. Urgent care bag was documented as being checked in January 2019. Lock numbers on the bag did not match the inventory lock number documented. Staff is placing a check mark that the cart and bag lock are present, but lock numbers are not being documented.
Log Books Deliverables	Recommendation from RHSA (b)(5) (b)(5)

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	44
Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	44

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Of the medication administrations observed, how many mouth checks were conducted?	
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	44
How many MAR entries were observed?	10
Of the MAR entries observed, how many were complete?	10
Of the MAR entries observed, how many medication refusals were documented?	10
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	10
Of the identified medication refusals, how many were high-risk medications?	4
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	4
Medication Administration Findings	None
Medication Administration Deliverables	None

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	0
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	0
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	0
Meetings Findings	Staff meetings are not being held monthly. The last staff meeting was April 2019. ICE/HSA meetings are being held but meeting minutes were not located in the scanned documenation. (b)(5)
Meetings Deliverables	1) Staff and PHSP meetings: SIte to send staff meeting minutes x 2 (May 2019 and June 2019) to RHSA by 1 JUL 2019. Meetings need to be regularly scheduled (i.e. reoccuring calendar meeting invite monthly)-Meeting schedule needs to be sent to RHSA in pdf format. Send a pdf copy of the meeting invite to the RHSA to show that it is reoccurring (a copy is needed, but the RHSA does not need to be cc'd on the actual meeting)

MHU Full Admission Chart Review - Review Complete

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How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	25
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	25
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	0
Of the MHU full admission records reviewed, how many had a nursing care plan?	25
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	1
Of the MHU full admission records reviewed, how many had patient education provided daily?	1
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	16
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	13
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	9
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	3
MHU Full Admission Records Findings	non urgent MH detainees didn't appear to be prioritized for MH follow-up however status may change quickly when non stationary
MHU Full Admission Records Deliverables	On average assess calendar dates to be effective for non urgent mental health status detainees.

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	2
How many patients are in the MHU full admission at the time of observation?	20
How many MHU full admission patients have a 24-hour chart review everyday?	20
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	20

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Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	20
MHU Full Admission Encounters Findings	MFO_MD_ChartAppr_YES (Yes/No options not available in the drop down menu)
MHU Full Admission Encounters Deliverables	None

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	22
Of personnel and credentialing files reviewed, how many were PHS officers?	8
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	0
Of personnel and credentialing files reviewed, how many were federal civil service employees?	1
Of personnel and credentialing files reviewed, how many were contractors?	7
Of personnel and credentialing files reviewed, how many records are for privileged staff?	6
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	4
Of the LIP staff records reviewed, how many had personnel files records current?	0
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	3
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	8
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	8
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	8
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	6
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	8
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	7
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	7

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Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	2
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	5
Of the staff records reviewed, how many had scope of practice documentation if applicable?	22
Personnel and Credentialing Files Findings	None
Personnel and Credentialing Files Deliverables	None

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	27
Of the physical exam charts reviewed, how many used language services?	10
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	10
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	10
Of the physical exam charts reviewed, how many had a pain assessment?	27
Of the physical exam charts with pain assessment, how many were addressed ?	27
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	17
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	9
Of the physical exam charts reviewed, how many were for adult females?	6
	6

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Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	0
Physical Exam Records Findings	Regarding the language services, the N/A represents that the staff member was able to translate for the provider or the provider was fluent in the detainee's native language. This was appropriately documented in the medical record. The majority of the females were pregnant and had appointments with OBGYN.
Physical Exam Records Deliverables	None

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	9
Of the physical exam encounters observed, how many included a full set of vital signs?	9
Of the physical exam encounters observed, how many were completed within the specified timeframe?	9
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	0
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	0
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	2
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	9
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	1
Physical Exam Encounters Findings	None
Physical Exam Encounters Deliverables	None

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	3
Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	Yes

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Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	3
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	0
Prescreen Encounters Findings	Only 3 Prescreen Encounters observed due to intake arrived during night shift and were completed prior to arrival at the facility. No level one encounters observed.
Prescreen Encounters Deliverables	None

Risk Management - Review Complete

Trends	Failure to refer to higher level of care from intake (3 cases have been identified at present; 2 resulted in hospitalization due to this breach in the intended process; Documentation of a RCA is completed for this identified process vulnerability; action plan implementation is in progress)
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	2
Number of RCAs or SOEs completed during the last six (6) months.	2
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	5
List all corrective actions identified in the preceding field and note their status and due dates.	All 5 caps are in progress: they have been developed and in implementation phase; Next follow up date for the action plans is June 30, 2019 and anticipated completion date: October 1, 2019.
Risk Management Findings	refer to information above; Overall excellent/commendable RM/FHPM/Facility leadership collaboration is noted.
Risk Management Deliverables	refer to information above

Schedules - Review Complete

How many schedules were reviewed?	10
Of the schedules reviewed, how many had a legend to explain codes?	10
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	10
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	10
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	10
Are there signed approvals for non-traditional shifts?	Yes

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Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	No recommendations
Schedules Deliverables	No deliverables

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	17
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	17
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	17
Of the segregation records reviewed, how many offered the patient daily sick-call services?	17
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	17
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	3
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	10
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	10
Segregation Records Findings	None
Segregation Records Deliverables	None

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	0
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	Question confusing. There were 3 total detainees in segregation. None in MHU. Rounds performed daily in Segregation and sick call offered daily.
Segregation Encounters Deliverables	None

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Shift Report and Time Cards - Review Complete

Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	No
Shift Report and Time Cards Findings	5 out of 15 time cards reviewed and changes were noted, but initials were not present on the time care. Inconsistent verification on time cards noted.
Shift Report and Time Cards Deliverables	Send random time cards to RHSA (10 total-5 for May 2019 and 5 for June 2019. Info due to RHSA by 1 JUL 2019.

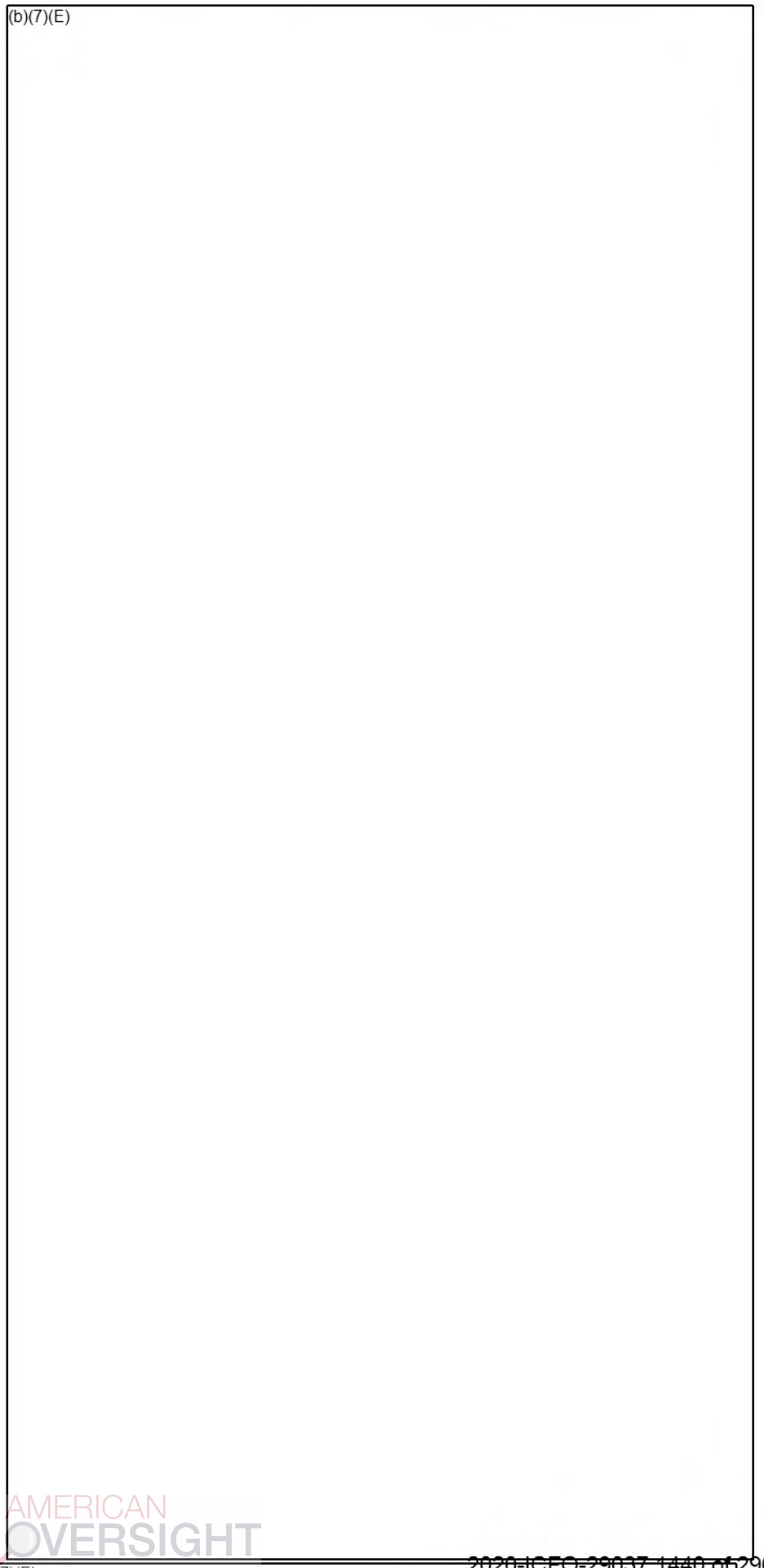
Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	5
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	4
Of the sick call records reviewed, how many included a full set of vital signs?	25
Of the sick call records reviewed, how many had a pain scale greater than 0?	13
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	12
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	23
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	25
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	25
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	Yes
Sick Call Records Findings	1 out of 5 patients was not referred to a provider. 12 out of 13 patients had a pain score indicated
Sick Call Records Deliverables	None

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Staffing Information - Review Complete

(b)(7)(E)



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Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed? 13

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Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	13
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	5
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	6
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	12
Of the suicide watch records, how many had a patient released from suicide watch?	13
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	13
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	12
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	13
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	13
Suicide Watch Pre-Audit Findings	Regarding the data for the Special Needs Forms questions: some of the information are placed in the treatment plan in the provider note and not on the Special Needs Forms.
Suicide Watch Pre-Audit Deliverables	By 1 JUL 2019-send RHSA random checks from SW between May-June 2019 to check SNF and note documentation. Reviews are not to exceed 5 charts checked.

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	0
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	0
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	0
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	0
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	0
Suicide Watch Encounters Findings	No detainees on Suicide Watch during site visit.
Suicide Watch Encounters Deliverables	None

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Training - Review Complete

How many training folders were reviewed?	25
Of the training folders reviewed, how many had a HSD-500?	25
Of the training folders reviewed, how many had a signed position description ?	10
Of the training folders reviewed, how many were registered nurse training folders?	10
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	10
Of the training folders reviewed, how many had continuing medical education credits documented?	10
Training Findings	None
Training Deliverables	None

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	0
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	0
Transfers Findings	25 charts were reviewed. 100% of the 25 authenticated appropriately (signed, stamped, and dated). All transfer summaries were completed by a LVN or above. 2 out of 25 charts did not have medical and mental health conditions listed. 3 of the 25 had medications and they were documented appropriately.
Transfers Deliverables	None
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	23
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	3

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Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	12
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	12
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	12
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	None
Workforce Health Files Deliverables	None

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	San Diego
Start Date	2017-04-16
End Date	2017-04-21
Status	Report Complete
Corrective Action Required?	Pending Determination
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Pending Report Completion
DAD, Clinical Services Review Status	Pending Report Completion
DAD, Health Care Compliance Review Status	Pending Report Completion
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Pending Report Completion

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1549.00
MHU Beds	38.00
Daily Adult Male Population	1159.00
Daily Adult Female Population	217.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	93.00
Comments	MHU = 6 negative pressure rooms, 14 single rooms and 2 nine bed dorms. Daily populaition is average of Jan, Feb and Mar.

Average Number of Encounters (Past 3 Months)

Prescreenings	1456.00
Intake Screenings	1423.00
Physical Examinations	1238.00
Vitals/Labs	806.00
Sick Call	5135.00
Pros/Imm	647.00
Acute	1042.00
Chronic	567.00
Mental Health	1319.00
Dental	596.00
Emergent/Urgent	532.00
MHU	1499.00
Segregation	3143.00
Admin	273.00
Transfers	1591.00
Pill-Line Passes	295.00
Prescriptions (Pill-line + KOP)	6392.00
Referrals/ER	492.00

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Comments	NO DATA

Staffing Information - Review Complete

(b)(7)(E)

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Accreditation - Review Complete

Last ACA Accreditation	2016-11-14
Last ACA Findings	Last ACA survey: November 15-15, 2016. No issues identified; the facility received 100/100.
Last NCCHC Accreditation	2014-01-06
Last NCCHC Findings	Last full NCCHC survey conducted January 6-8, 2014. Initially found non-compliant with two essential standards: J-A-04; Administrative Meetings and Reports J-A-07; Emergency Response Plan Health staff meets monthly to discuss health services operations. Attendees include the responsible physician, staff physicians and mid-level providers, the HSA and assistant HSA, mental health and nursing staff, dentist, pharmacist, and medical records representative. We reviewed the meeting minutes and attendance rosters. However, the warden does not receive monthly statistics on health services utilization; rather, these are given to Iha AFOD as we were told that medical activities were ICE management concerns, ahd not for the purview of the warden. The standard is not met. Corrective action is required for Compliance Indicator #4. Statistical reports of health services should be made at least monthly and provided to the facility administrator. The Intention of the standard is to facilitate joint monitoring of the health care delivery system. The following is acceptable documentation for compliance: copies of the next two monthly statistical reports with evidence that they were received by the facility administrator. In order to receive accreditation, verification that this standard has been met is required. J-A-07 E!mergency R111sponse Plan(!!!). Disaster drills have been held and documented as required. The 2011 and 2012 drills involved health staff and were critiqued and shared with them. Man-down drills have also been documented appropriately, including the sharing of critiques. However, the 2013 disaster drill did not involve medical staff, except for one representative who was asked to attend. The intent was to have the nurse then communicate the training back to the medical staff; however, the staff we interviewed indicated that they were unaware of the drill and confirmed they had little to no involvement. This drill occurred during the day shift, when numerous staff was present. We discussed the benefit of having all available staff participate with the HSA. The standard

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	Is not met. Corrective action is required for Compliance Indicator# 2. At least one mass disaster drill should be conducted annually so that over a three-year period, each shift has perticipaled. Practicing the emergency response plan makes health staff better able to respond to disasters when they occur in order to protect the health, safety, and welfare of inmates, staff, and visitors. When actual emergencies, whether or not they involve injuries, are critiqued, the intent of the standard is met. Acceptable documentation includes a plan by the RHA that addresses how this shift will be brought up to date with practicing the mass disaster (or by critiquing actual an actual event). In order to receive accreditation, verification that this standard has been met is required. The facility provided their corrective action plan, which was accepted by NCCHC. The facility was re-accredited. NOTE: NCCHC also did a partial-day visit to the new Otay Mesa facility on June 14, 2016. Because the facility had undergone a name change (from San Diego to Otay Mesa) and moved into a new building, NCCHC wanted to ensure their mission was still the same, and that the name change and move would not impact their accreditation status. No issues were identified from that visit.
Last PBNDS Accreditation	2017-03-28
Last PBNDS Findings	The site had a PBNDS inspection 3/28-3/30/2017. Per the HSA, no medical findings were noted. Pending the final report from Nakamoto.
Comments	NO DATA

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Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	14.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	24.00
Number of informal grievances.	0.00
Findings	None. LOP in place, grievance officer identified with an appeal process in place. Note in eCW identified.
Deliverables	NO DATA

Risk Management - Review Complete

Trends	1 pending RCA
Number of active RCAs/SOEs	1.00
Number of RCAs or SOEs completed during the last six (6) months.	1.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	1 pending RCA for a detainee who has had 2 suicide attempts and eventually had a hospitalization. Following the hospital discharge, medications were not continued.
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	0.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	No findings noted
Deliverables	NO DATA

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	Yes
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	Yes
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	N/A - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	All drills are being completed and include all shifts. Scenarios reviewed included a heart attack, hanging and anaphylaxis. All equipment checks done and training complete.
Deliverables	NO DATA

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Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	No - See findings below.
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	Entry to negative pressure rooms is from a locked hallway. One entry is marked with signage indicating proper entry requirements and the other is not. No signs noted on any of the doors to the isolation rooms.
Deliverables	NO DATA

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	2.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	2.00
Number of psychotropic consent forms among the identified consent forms.	4.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	4.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	4 out of the 25 charts reviewed had psychotropic consent forms. 2 of the charts had dental consents. Review additional dental and psychotropic consent forms on site. A# (b)(6); (b)(7)(C) had a diagnosis of Major Depressive disorder but no psychotropic medication on EMAR.
Deliverables	NO DATA

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	22.00
Out of the transfers reviewed, how many had a positive chest X-ray?	4.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	3.00
Out of the transfers reviewed, how many have active TB?	4.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	3.00
Number of transfers with medication instructions clearly provided.	3.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) CXR Date indicates 06/26/2017, should be 6/15/15 as indictd in on the transfer summary from BOP. (b)(6); (b)(7)(C) TB Clearance Modality was through Symptom Screening only, without documentation of CXR entered into eCW. Negative CXR dated 1/12/16 was per transfer summary from MCC, but no transfer summary was scanned into eCW (b)(6); (b)(7)(C) Transfer summary indicates that detainee is not being treated for active TB, but has TB medications listed on summary. Also transfer summary does not reference attached TB-CM with AFB lab results.
Deliverables	NO DATA

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Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	7.00
Number of prescreens that used a translator.	0.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	0.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	25.00
Number of prescreens with documentation completed in eCW prior to intake screening.	10.00
Findings	Out of 25 charts reviewed, only 7 were triaged per pre-screen policy. There were 8 records reviewed that listed disposition as "medically cleared for custody." That is not in accordance with the pre-screen policy, which indicates that the priority level must be listed, ie. No Priority, Priority-1, etc. Out of 25 records reviewed, 15 pre-screens were completed in e-CW, AFTER the intake screening.
	(b)(5)
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	5.00
Number of prescreen encounters observed that allowed for patient privacy.	5.00
If privacy was not provided, where was the prescreen performed?	Screenings are conducted in a secured outside perimeter once detainee leaves transportation vehicle and prior to entering the facility. Each detainee is separated and asked prescreening questions. Detainees not being interviewed cannot hear the questions being asked by the medical staff.
Number of prescreen encounters that used language services.	3.00
Number of prescreen encounters completed within two hours of arrival.	5.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	5.00
Number of prescreen encounters prioritized.	1.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	1.00
Findings	Prescreenngs observed were conducted in accordance with policy. It was noted that prescreenings were prioritzed and seen first.
Deliverables	NO DATA

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	12.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	12.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	13.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	25.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	25.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	1.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	1.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	24.00
Number of intake screenings with clinically significant findings.	12.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	5.00
Number of intake screenings reviewed by an RN or above within 24 hours.	0.00
Findings	Of the 25 intake charts reviewed, 5 of them were conducted by a LVN. All five charts were reviewed and signed off by a RN, but none of them were signed off within 24 hrs. Two Intakes were conducted on 1/2/17, but not signed off by the LVN until 1/4/17. Three other intakes were conducted on 1/5/17, but not signed off until 1/7/17.

(b)(5)

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(b)(5)

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(b)(5)

Deliverables	NO DATA

Intake Screening Observations - Review Complete

Number of intake screenings observed.	1.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	1.00
Number of intake screening observations where a full set of vital signs were taken.	1.00
Number of intake screening observations that used language services.	0.00
Of the intake screening observations that used language services, how many were appropriately conducted?	0.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	1.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	1.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	Detainee spoke english and no language services were needed. Was only anble to observe one (1) intake of the group of five as during the process one of the detainees was creating a disturbance to the (b)(7)(E) (b)(7)(E) and all intakes were halted during this period.
Deliverables	NO DATA

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Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	25.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	25.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	25.00
Number of chronic care encounters with psychiatric medications.	0.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	0.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	0.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	0.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	21.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	21.00

Findings

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	(4) charts did not have global alert (4) charts did not have baseline medical data
Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	3.00
Number of chronic care encounters observed that utilized language services.	1.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	3.00
Findings	No findings. Chronic care treated appropriately.
Deliverables	NO DATA

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	6.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	6.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	24.00
Number of physical examinations with pain assessment.	3.00
Of the physical examinations with pain assessment, how many were addressed?	3.00
Number of physical examinations with clinically significant findings.	25.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	25.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	24.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	(1) chart did not have physical exam completed within 14 days (1) chart did not have a physical exam reviewed within required timeframe.
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	4.00
Number of physical examination encounters with a full set of vital signs taken.	4.00
Number of physical examination encounters observed that were completed within 14 days.	4.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	4.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	There were signs in all clinic areas offering chaperones. The RN listed me as a chaparone for the PEs that I observed.
Deliverables	NO DATA

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Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	7.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	5.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	13.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	13.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	10.00
Number of sick call encounters where the reason is documented in the "Reason" field.	24.00
Number of sick call encounters where the reason for the visit was from an approved category.	25.00
Number of sick call encounters addressed by a nurse.	19.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	18.00
Findings	Recommend review of IHSC Sick Call Guide. 5 out of 7 SC encounters that required referral did not have a referral documented (b)(6); (b)(7)(C) RN documented the need for referral, but the appt for referral was not documented. RNGL not referenced by name (of note, education was documented, but the specific GL used was not listed) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) One chart did not have the correct nursing diagnosis listed- (b)(6); (b)(7)(C) (SC reason listed as cough, but the pt c/o leg pain-pain not listed as a reason, RNGL for pain/cough not listed). Reason not listed in SC field- (b)(6); (b)(7)(C)

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Deliverables	NO DATA

Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	Yes
Findings	Observed detainees being seen by Nursing staff and MLP staff for sick call. Detainees that were seen by MLP for sick call were appropriately referred and treated. No findings.
Deliverables	NO DATA

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	0.00
Number of MHU 23 hour observation records with discharge encounters.	0.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	0.00
Number of MHU 23 hour observation records with telephone order admission.	0.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	0.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	No 23 hour observation charts found.
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	N/A - See findings below.
Number of nurses in the MHU at time of observation.	1.00
Number of patients in the MHU at time of observation.	1.00
Number of MHU full admission records reviewed.	25.00
Number of MHU full admission records with admission encounters.	24.00
Number of MHU full admission records with discharge encounters.	18.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	25.00
Number of MHU full admission records with no PE within the past year.	0.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	0.00
Number of MHU full admission records with acuity level assigned.	23.00
Number of MHU full admission records with all medications placed on pill line.	25.00
Number of MHU full admission records with 24 hour chart reviews everyday.	25.00
Number of MHU full admission records for patients in segregation for medical overflow.	0.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0.00
Number of MHU full admission records with a nursing care plan.	25.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	8.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	8.00

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Number of MHU full admission records with mental health diagnoses.	17.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	17.00
Number of MHU full admission records without mental health diagnoses.	8.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	8.00
Findings	- (1) record without admission encounter - (7) records without discharge encounters - (2) records without acuity level assigned - (17) records not did not address nursing plan daily and patient education not offered daily
Deliverables	NO DATA

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Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	13.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	13.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	13.00
Number of suicide watch records where the need for finger foos was annotated.	13.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	13.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	13.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	13.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	13.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	9.00
Findings	This reviewer only found 13 charts. 4 charts did not have custody checks scanned into the chart- (b)(6); (b)(7)(C)
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	No detainees were on or placed on suicide watch during site assessment.
Deliverables	NO DATA

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Hunger Strike - Review Complete

Number of hunger strike records reviewed.	3.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	2.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	3.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	3.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	1.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	1.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	3.00
Number of hunger strike records with special needs.	0.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	0.00
Findings	This reveiwer only found 3 Hunger Strike. Recommend review of HS policy onsite to include need for special needs form, charting of orthostatic BPs, and completion of inital evaluation.
Deliverables	NO DATA

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Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	18.00
Number of segregation records where daily segregation rounds by nursing are documented.	20.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	20.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	23.00
Number of segregation records where the patient was seen weekly by mental health.	21.00
Findings	- (7) records did not indicate that patient was medically cleared - (5) records did not indicate that patient had daily segregation rounds by nursing - (2) records where the patient's mental health status was not evaluated every 30 days - (4) records where the patient was seen weekly by mental health
Deliverables	NO DATA

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After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	10.00
Number of after hours medication records with the patient's identification number documented.	9.00
Number of after hours medication records with medication order(s) documented in eCW.	7.00
Number of after hours medication records that were generated by a nurse as a telephone order.	2.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	2.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	Facility utilizes a system of one key and requires two (2) signatures anytime something is removed from the night stock. One entry did not have an A# listed and charge nurse is looking into this. Some medications were noted to have been given during sick call and urgent care encounters on the weekends or after pharmacy had left. Findings were reviewed with pharmacist who explained the above listed were acceptable.
Deliverables	NO DATA

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No - See findings below.
Are after hours medication orders documented as dispensed in eCW?	No - See findings below.
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	Log does not reflect the time medication was removed. Use of some medications there was already an existing order in eCW and the medication was used to fill that order, i.e. return from outside appointment and KOP medications not avilable due to being housed in MHU to be seen by provider. Findings were reviewed with pharmacist who explained the above listed were acceptable.
Deliverables	NO DATA

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Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	25.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	25.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	2.00
Reasons for why a translator was not used.	23 out of 25 charts reviewed documented English as primary language. 2 charts spanish indicated as the primary language. Interpretor numbers were listed for the 2 two charts with spanish as primary language.
Findings	N/A
Deliverables	N/A

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	Facility has a process in place to utilize sign language interpretors and TDD/TYY phones for individuals with hearing disabilities. Discussed with HSA that the site would benefit if an LOP was in place for staff guidance.
Deliverables	NO DATA

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Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	CLIA Waiver expires 05/17/2017
Deliverables	NO DATA

AMERICAN OVERSIGHT

Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	18.00
Number of refridgerator temperature logs that are up to date.	18.00
Number of refridgerator temperature logs that are out of range.	4.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	It was found that out of the 18 temp logs checked, 4 nursing station medicine refrig temp logs were out of range by 1 degree. Specifically, they were read at 37 degrees and no notification was sent to pharmacy as required when temp is over 36 degrees as per local policy. The temp range is written on the log with instructions on what to do if an out of range temperature is logged. HSA addressed at shift report and corrective action was taken.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	3.00
Number of daily assignment sheets completed and archived .	3.00
Number of daily assignment sheets with one emergency team identified per shift.	3.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	2.00
Number of daily assignment sheets with clinic inspection completed and signed.	0.00
Are detainee referrals documented?	Yes
Findings	Clinic inspection is logged seperately and not reflected on the shift report
Deliverables	NO DATA

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	Report done on time and thorough. No findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	6.00
Number of federal civil service employee personnel files reviewed.	0.00
Number of contractor personnel files reviewed.	14.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	Yes
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	5.00
Of the personnel file records for priveleged staff, how many are current?	5.00
Number of personnel files with current and signed Health and Ability form.	20.00
Number of personnel files with a signed statement of confidentiality (one time).	20.00
Number of personnel files with a signed statement of risks and responsibility (one time).	20.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	20.00
Number of personnel files with a signed release of information form (one time).	20.00
Findings	No findings.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	6.00
Number of federal civil service employee credentialing files reviewed.	0.00
Number of contractor credentialing files reviewed.	14.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	20.00
Number of credentialing files with current, valid, and unrestricted license.	20.00
Number of credentialing files with license primary source verification.	20.00
Number of credentialing files with documentation of primary education.	20.00
Number of credentialing files with education primary source verification.	20.00
Number of credentialing files reviewed for physicians or psychiatrists.	2.00
Number of physician or psychiatrist credentialing files with documentation of residency.	2.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	2.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	2.00
Number of credentialing files with a curriculum vitae or resume.	20.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	4.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	4.00
Number of credentialing files with scope of practice.	18.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	4.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	20.00
Number of peer reviews reviewed.	15.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	15.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	Credentialing folders well organized. 1 out of 20 folders needed the scope of practice to be signed. 1 out of 20 folders needed an updated scope of practice. 2 of the 6 officers were new and did not have two years of COERs as well as LOAs.
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	6.00
Number of employee health files with current TB (PPD or CXR) documentation.	6.00
Number of employee health files with current Hepatitis B vaccination or declination form.	6.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	4.00
Number of employee health files with current respirator medical clearance.	6.00
Number of employee health files with current respirator fit test.	6.00
Number of employee health files with emergency contacts.	6.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	Yes
Findings	No findings.
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	10.00
Number of training folders with HSD-500.	0.00
Number of training folders with a signed position description.	0.00
Number of registered nurse training folders reviewed.	5.00
Number of registered nurse training folders with RN Physical Exam Training.	0.00
Number of training folders with continuing medical education credits.	10.00
Number of training folders with BLS for health care providers or CPR and AED certification.	0.00
Number of radiation safetoy officer training folders with radiation safety training.	0.00
Findings	The HSD-500, position description, RN Physical exam training and BLS certificates are located in the personnel or credentialling files.
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	Yes
Findings	No findings
Deliverables	NO DATA

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Schedules - Review Complete

Number of schedules reviewed.	5.00
Number of schedules with a legend to explain codes.	5.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	5.00
Number of schedules with evenly distributed staffing throughout the week.	5.00
Number of schedules with provider coverage on weekend/holidays.	5.00
Number of schedules with actual work hours reflected for non-traditional shifts.	5.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	Facility schedules on five (5) eight hour shifts per week. There is only one approve, non-traditional shift, to accomidate pill line
Deliverables	NO DATA

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Facility: OMDC **Reviewers** (b)(6); (b)(7)(C) **Dates:** 8/31/18

IHSC Health Systems Assessment

Facility Overview

Months: May-June 2018 **Bed Capacity:** 1572 **MHU Beds:** 32

Daily Census: 1409 **Male:** 1148 **Female:** 229 **Juveniles:** 0 **LOS:** 87

Average Number of Encounters					
Category	**Month 1**	**Month 2**	**Month 3**	**Average**	**%pop**
Pre-screening	753	516	525	598	
Intake	737	508	514	586	
Physical Exams	594	516	524	544	
Vitals/Labs	588	571	631	596	
Sick call	1699	1676	1549	1641	
Pros/Imm	272	283	285	280	
Acute	468	450	390	436	
Chronic	97	142	118	357	
Mental Health	629	584	574	596	
Dental	154	144	128	142	
Emergent/Urgent	276	206	251	244	
MHU	991	940	903	945	
Seg	1147	1221	1313	1227	
Admin	241	216	204	220	
Transfers	739	601	638	659	
Totals	9385	7634	8547	9071	
Pill-line passes	1239	1251	1157	1216	18%
RX (Pill-line + KOP)	2025	2019	1878	1974	51%
Referrals / ER	33	52	66	50	

(b)(7)(E)

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DHS-ICE-20-0618-A-000488

Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

PRE-ARRIVAL REVIEW

Accreditation

Most recent ACA, NCCHC, and PBNDS surveys. List type of survey and date.

Evaluation Method		
Survey	**Date**	**Findings / Recommendations**
ACA	Nov 14-15, 2016	
NCCHC	June 14-16, 2017-	
PBNDS	Jan 23-25, 2018	
Comments	All update to date and completed.	

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Grievances

Evaluation Method:	Observation	
Items to Review *(review 100% during past year)*	**Yes, No, or N/A**	**Comments**
1. Have there been any medical grievances reported through QI/JIC/CRCL/DRIL *(if so, provide type in comment section)*	Yes	Reported at monthly staff meetings, all staff receive annual live training on the grievance process in the facility, reported in QI/QA meetings.
2. Is there a local procedure (SOP) for managing grievances?	Yes	LOP
3. Is there an identified grievance officer?	Yes	LCDR (b)(7)(E)
4. Is the log book kept and up to date?	Yes	Log book encrypted on local share drive.
5. Were all Grievances addressed in a timely manner?	No	9 past deadline.
6. Number of Formal/Informal grievances: 0 / 3		Formal 238 as of 8/29/2018. No informal tracked.

Findings/ Recommendations:	. 9 addressed late out of 238 = 2.1%. Log shows who was late (1 person late 6 times) all will be informed by MGO and HSA on importance on timely adjudication.
Deliverables:	**N/A**

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Incident Reports/RCA/SOE

Evaluation Method:			
Items to Review *(review 100% during past year)*		**Yes, No, or N/A**	**Comments**
1. Were there any trends noted from reported incident reports or RCAs for FY17?		No	
2. Are there any active RCAs/SOE?		No	
3. Has a RCA or SOE been completed during this FY? If so, complete #4		No	
4. Was a CAP initiated and/or completed for the RCA or SOE?		No	
a. If CAP initiated, note status and due date.			
Findings/ Recommendations:			
Deliverables:			

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On-Site Observations

During site observations, the reviewers should observe staff members carrying out the task, interview staff, review medical records and review supporting documents (i.e. logs, minutes, binders, electronic trackers, etc.).

Medication Administration (Observations-Onsite Review)

Question (10 ENCOUNTERS)	Improvement Plan (1,2, or 3)	Comments
Is pre-pouring occurring? **(Be sure to observe more than one nurse on multiple shifts) Level 2@100%**		No
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)? **Level 2 @100%**		Yes
Are mouth checks being conducted with every administration? Observe 10 patients (if possible) on multiple shifts **Level 1 @80%**		Yes
Are all entries in the MAR complete (allergies, staff initials, etc.)? Observe 10 different MAR; **Level 1 @80%**		10 of 10
Are nurses documenting the medication administration immediately after the medication is administered**? Level 2 @100%**		yes
Number of all medication refusals documented on the MAR/eMAR **Denominator**		6

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Of the identified medication refusals from the MAR, how many refusals did have an accompanying signed refusal form? **Level 2@90%** .		6
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal in eCW **Level 1 @100%; See guide eon ECW notification**		0

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Emergency Preparedness and Response

Question	Improvement Plan (1,2, or 3)	Comments
Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)? Refer to guide: **level 1 @90%** Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)? Refer to guide **level 1 @90%** Is there documentation showing completed date and time of mass casualty drills * (each shift should have a complete drill within a three year period)? *Table top/mock drills are acceptable replacements for drills not conducted facility wide Refer to guide: **level 1 @90%** Are clinic staff trained on emergency equipment (AED, first Aid kits, fire extinguisher, etc?) Yes/No **level 1 @90%**		yes yes yes yes
Do emergency scenarios vary? Yes/No?? **Level 100% if No**	yes	
Is the difference between a drill and an actual event evident in the write-up?): **Level 1 @100%**	yes	
Is there process in place to distribute "an after-action report to all staff? **Level 1 @90%:**	yes	
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event? **Level 1 @100%**	yes	
Comments:	all within compliance	
Deliverables:	none	

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Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Consent Forms

	Chart Reviews		
	Question	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1.	Number of consent forms (General consent) that were complete (not missing detainee signature, witness, or date). **Level 1 @100%:** Can escalate to Level 2 if not resolved by the completion of the assessment		25
2.	Number of dental consent forms among the identified consent forms.		6
3.	Number of dental consent forms that were complete (missing detainee signature, witness, or date) **Level 1 @90%**		6
4.	Number of psychotropic consent forms among the identified consent forms.		10
5.	Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date) **(Level 1 @90%)**		9
Findings/ Recommendations:			
Deliverables:	None		

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Facility: OMDC **Reviewers** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Transfers

Reviewer

Evaluation Method:	Section Completed Under the Pre-Audit Chart Reviews	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of outgoing transfers authenticated appropriately (signed, stamped, and dated): **Level 1 @100%**	Level 1	25
2. Number of outgoing transfers completed by LVN or above. **Level 1 @100%,**	Level 1	25
3. Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility) Level 2 @90%	Level 1	25
4. Of the 25 transfers reviewed for TB clearance documentation, how many correctly documented no TB treatment status? **see guide Level 2@90%**	Level 2	9 out of 9
5. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented no TB treatment status? see guide **Level 2@90%**	Level 2	6 charts state was still on tx. at time of release, but in template documented is NOT on tx.
6. Of the 25 transfers reviewed for TB clearance documentation, how many - correctly documented TB treatment status? see guide: **Level 2@90%**	Level 2	10 of 10
7. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented TB treatment status? see guide: **Level 2@90%**	Level 2	0

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Findings/ Recommendations:	Some nurses were documenting patient not on TB treatment when RIPE Tx was listed under Current Medications.
Deliverables:	This finding was reviewed at August's staff meeting and will also be further reviewed by the Nurse Manager. Nurses were reminded that transfer summaries with chronic care and meds must be reviewed/signed by an RN.

Pre-Screening

Reviewer:

Evaluation Method:	**Observe 10 pre-screens if Possible**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of prescreen encounters observed. **Denominator**		10
2. Are language services being used during pre-screen if appropriate? **Level 2: if No**		yes
3. Number of prescreens with documentation completed in eCW prior to intake screening. **Denominator**		10
4. Number of prescreen encounters prioritized. **Level 1: @90%**		10
5. Number of Pre-screens encounters not prioritized appropriately: **Level 1 @90%**		0
Findings/ Recommendations:		

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Facility: OMDC **Reviewers** (b)(6); (b)(7)(C) **Dates**: 8/31/18

Intake Screening

Evaluation Method:	Observe 10 "Intakes" if Possible		
Items to Review *(review 25 records in the past month)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of intake screenings observed. (N/A) **Denominator**			25
2. Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening. **Level 1 @90%**			25
3. Number of intake screening observations where a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat were taken. **Level 2: @90%**			25
4. Number of intake screening observations that used language services. **Level 2:@90%**			25
5. Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)? **Level 1 @90%**			25
6. Of the intake screening observations that used language services, how many were appropriately conducted? **Level 2:@90%**			25
7. Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide. **Level 2:@90%**			25

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8. Number of intake screening observations with security advice of special needs and housing disposition. **Level 1 @90%**		
Deliverables:		

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Chronic Care

Evaluation Method:	Observe 10 "Chronic Care Encounters"		
Questions		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of chronic care encounters observed that utilized language services appropriately. **Level 2 @90%**			Yes, 100% compliant
2. Number of chronic care encounters observed that were completed within the time frame indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit **Level 2 @90%**			Yes, 100% compliant
3. Number of chronic care encounters observed that were not completed within the timeframe indicated by a previous visit (greater than 90 days for unstable patients). **Level 2 @90%**			0
Findings/ Recommendations:			
Deliverables:			

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Physical Exams

Evaluation Method:	Observe 10 physical exams completed by different providers

Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of physical examination encounters with a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken **Level 2@90%**	2	90% One PE did not have O2 sat but had all other measures of vital signs
2. Number of physical examination encounters observed that were completed within the specified timeframe. (Two Business days for PE-Cs, 7 days for –juveniles and, 14-days for adults) **Level 2@90%**		Yes, 100% compliant
3. Number of physical examination encounters observed that offered detainee provider referral when appropriate **Level 1 @90%**		Yes, 100% compliant
Findings/ Recommendations:		
Deliverables:		

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Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Sick Call

Evaluation Method:	Observation		
Items to Review *(Observe 10 "Sick Call "Encounters if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Is sick call offered face-to-face on a daily basis?? **Level 1 if NO**			yes
2. Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented) **Level 1; if NO**			yes
3. Is translator services offered when appropriate during a sick call process? **Level 1; if NO**			yes
4. Did RN utilize nursing protocols/guidelines during sick call encounters?			yes
5. Is a guardian present for any minor (<18 years of age) sick call? **Level 1; if NO and applicable**			n/a
6. Is there a sick call log used to document all encounters?			yes
Findings/ Recommendations:			
Deliverables:			

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Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Medical Housing Unit 23 hr Observation

Evaluation			
Items to Review *(Observe 10 MHU 23-HR OBS if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU 23 hour observation records reviewed. **Denominator**			10
2. Number of MHU 23 hour observation records with documentation regarding return to general population			10
3. Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis documented on placement in the medical housing unit			10
4. Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 2 business day. **Level 1: @80%**			10 r/o TB on evening shift.
Findings/ Recommendations:			
Deliverables:			

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Facility: OMDC **Reviewers**: (b)(6); (b)(7)(C) Dates: 8/31/18

Medical Housing Unit full Admission Observation

Evaluation Method:	Observation		
Items to Review *(10 detainees if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are all patients within sight or hearing of a qualified health professional? **Yes/No**??			yes
2. Number of nurses in the MHU at time of observation **(Denominator)**			2
3. Number of patients in the MHU at time of observation			26
4. Number of MHU full admission records with 24 hour chart reviews every day. (Review one 24-hour chart in detail to confirm review was done appropriately) **Level 1: @90%**			10
5. Number of MHU full admission records with all medications (except KOP med exceptions see guide) placed on pill line. **Level 2 @90%**			26
Findings/ Recommendations:			
Deliverables:			

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Facility: OMDC **Reviewers**: (b)(6); (b)(7)(C) Dates: 8/31/18

Suicide Watch- Observations

Evaluation Method:	None observed on Site; no watches at time of audit		
Items to Review *(Observe 10 detainees on "suicide watch" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of patients on suicide watch **Denominator**			n/a*
2. Number of patients on suicide watch with nursing assessment performed within the past 8 hours. **Level 3 @ 100%**			n/a
3. Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule. **Level 3@ 100%.**			n/a
4. Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours. **Level 3 @ 100%.**			n/a
5. Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc). **Level 3@ 100%**			n/a
Findings/ Recommendations:			
Deliverables:			

AMERICAN OVERSIGHT

Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Hunger Strike - Observations

Reviewer:

Evaluation Method:	10 records reviewed; no hunger strikes during observation time		
Items to Review *(Observe 10 detainees on "Hunger Strike" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Was water available to detainees on hunger strike? **Level 3: if NO @90%**			yes; housed in MHU
2. Were meals (if observed during meal times) offered to patient and how MUCH OF THE of the food SERVED was eaten **Level 3: If NO @90%**			Not observed; no documentation specifying this.
3. Of the hunger strike records with special needs, how many records indicate that the needs were addressed? **Level 3 @90%**			when observed in past year, all have worn safety smocks and sack meals given
Findings/ Recommendations:			
Deliverables:			

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Facility: OMDC **Reviewers:** (b)(6); (b)(7)(C) **Dates:** 8/31/18

Segregation- Observations

Reviewer:

Evaluation Method:	record review		
Items to Review *(Observe 10 detainees in "Segregation" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU full admission records for patients in segregation for medical overflow. **(Denominator)**			0
2. Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on every 8 hours according to MHU policy **Level 3 @90%**			N/A
3. Was sick call offered to detainees in segregation or other specialty housing units? **Level 2 @90%**			Yes
Findings/ Recommendations:			
Deliverables:			

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After-Hours Medication (night pharmacy)

Reviewer:

Evaluation Method:	Observation		
Items to Review		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of after-hours medication log records reviewed. **(Denominator)**			10 log records reviews
2. Number of after-hours medication LOG records that were generated by a nurse as a telephone order. **Level 2 @90%**			10/10 = 100%
3. Number of afterhours medication records that were generated by a nurse as a telephone order and were signed by a provider within 24 hours returning for next work shift **Level 2 @90%**			10/10 = 100%
4. Does the pharmacy have a reconciliation process?: **Level 2 if NO @90%**			Yes; check start/stop emails, eCW notes, process orders in CIPS
5. Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed from the AHC: **Level 1 @100%**			Yes
6. Is all necessary information entered the fields of the After-Hours Cabinet (AHC) sign out log. **Level 1 @100%**			No; patient name missing, only A# written in log
7. Is a medication log in place and reflective of quantities of medication			Yes

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stored in the night cabinet? **(Level 1 if NO)**		
8. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed? **Level 2@100%: if NO**		No: time not included
9. Is the after-hours verbal medication order entered eCW by the prescriber upon return to duty? **Level 2@100%**		Yes
10. Is the after-hours medication administration properly documented on the MAR or in the electronic health record? **Level 2@100%**		Yes
11. Is the night cabinet, clean, stocked, and organized?		Yes
12. Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications? **Level 2@100%**		Yes: tech checks cart 2-3/week to restock and on
Findings/ Recommendations	New inventory log sheet created with separate columns for patient name and time.	
Deliverables:	None	

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Language Access- Observations

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are the "I Speak" posters and pocket guides readily available and posted in the clinic?		Yes
2. Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities? **If No; level 2; @100%**		yes
Findings/ Recommendations:		
Deliverables:	none	

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Diagnostic Services

Evaluation Method:	Observation		
Items to Review		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are laboratory services provided in adherence with CLIA Waived testing? **Level 3: @90%**		N/A	Yes
2. Is there a current certificate for CLIA-waived testing? **Level 2@100%: CLIA services stopped until obtained.**		N/A	Yes
3. Are radiation signs posted on all doors leading to areas with radiation producing equipment? **Level 1 @100%, "SPOT-FIX, may escalate to Tier 2 If multiple rooms noted not addressed by the end of the visit**		N/A	Yes
4. Are Dosimetry reports reviewed quarterly (MONTHLY FOR DECLARED PREGNACIES) by the Compliance officer or HSA? (Yes/No): **If No level 2@100%**		N/A	Yes
5. Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment? **Level 2@100%**		N/A	Yes

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6. Are staff dosimeter badges and controls stored in a central location and not near a radioactive source? **Level 2@ 100%**	N/A	Yes
Findings/ Recommendations:	all measures within 100% compliance	
Deliverables:	None	

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Log Books

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of pharmacy refrigerator temperature logs reviewed **(Denominator)**	N/A	25
2. Number of pharmacy refrigerator temperature logs that have entries per shift for the past three months. **Level 1 @90%**	N/A	25 - completed daily; no missing entries
3. Number of refrigerator temperature logs that are out of range. **(Denominator)**	N/A	0
4. Of the refrigerator temperature logs that are out of range, how many logs have documentation of action taken and follow-up ?(**Level 1 @90%)**	N/A	0
Are the sharps secured and count accurate? **Level 2 @100%, if NO**	N/A	yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes ?(**Level 1 @90%)**	N/A	no
Are the narcotics secured, (double locked) and counts within the last 3 months accurate (clinic and pharmacy supply)? **Level 3 @90%**	N/A	yes
In review of 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts? **Level 1 @90%**	N/A	yes, all with 2 signatures

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Are the urgent care cart/trauma bag and AEDS checked daily for content (signatures, AED functionality, and expiration for the past 3 months? **Level 2 @90%**		Yes
Findings/ Recommendations:	NM has already implemented procedure -- specific nurses assigned each shift	

Daily Assignment Sheet (DAS)

Evaluation Method:	Observation	
Items to Review *(review 10 random days)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of daily assignment sheets reviewed per month) **Denominator**	10	
2. Number of daily assignment sheets that were archived appropriately.	100%	*No IP level; Observation only for 2018 audits*
3. Number of daily assignment sheets reviewed had at least one emergency team identified per shift. **Level 1 @90%**	90%	Missing documentation for random shifts
Findings/ Recommendations:	None Will ensure that all shifts have documentation of emergency teams.	
Deliverables:	None	

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Facility: OMDC	Reviewers: (b)(6); (b)(7)(C)	Dates: 8/31/18

Shift Report and Time-cards

Reviewer:

Evaluation Method:	Observation		
Items to Review *(audit 10 random cards)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are shift reports conducted?		*Yes*	*No IP level: best practice*
2. Is there at least one representative from each department?		*Yes*	*No IP level: best practice*
3. Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?		*Yes*	*No IP level Observation only for 2018 audits*
Findings/ Recommendations:			
Deliverables:	NONE		

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Facility: OMDC	Reviewers: (b)(6); (b)(7)(C)	Dates: 8/28/18

Meetings

Reviewer:

Evaluation Method:	Observation

Items to Review (*Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings*)	Improvement Plan Levels (1,2, or 3)	Comments
1. Out of the two previous staff meetings, how many were conducted monthly and properly documented? **Level 1 @80%**	N/A	both were 100% compliant
2. Out of the two previous public health, safety, and preparedness meetings, how many were properly documented? (**Level 1 @80%**)	N/A	both were 100% compliant
3. Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented? (**Level 1 @80%**)	N/A	both were 100% compliant
4. Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented. **Level 1 @80%**	N/A	both were 100% compliant

Findings/ Recommendations:	**None**
Deliverables:	None

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PERSONNEL

Personnel and Credentialing Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files each if available*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the 12 personnel and credentialing files reviewed how many were PHS officers **No IP level**		4 files
2. Of the 12 personnel and credentialing files reviewed how many were federal civil service employee **No IP level**		none, we have no GS employees
3. Of the 12 personnel and credentialing files reviewed how many were contractors		8 files
4. Does the facility have a process for tracking requirements electronically?: **No IP level**		Yes
5. Of the 12 personnel and credentialing files reviewed how many records are for privileged staff (physician, psychiatrist, psychologist, dentist, and social worker)?: **No IP level**		2 files
6. Of the 12 Privileged staff that are Licensed Independent Practitioners (LIPs) how many had current personnel files records current? (Yes/No) **Level 2@100%**		2 files
7. Of the 12 personnel files reviewed, how many contained a current and signed Health and Ability form? **Level 1 @90%**		12 files
8. Of the 12 personnel files reviewed, how many contained a signed statement of confidentiality (one –time statement signed by		12 files

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staff) **Level 1; @90%**		
9. Of the 12 personnel files reviewed, how many contained a signed statement of risks and responsibility (one time)?		12 files
10. Of the 12 personnel files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time). **Level 1; @90%**		12 files
11. Of the 12 personnel files reviewed how many contained a signed release of information form (one time). **Level 1; @90%**		12 files
13.Of the 12 credentialing files reviewed, how many contained current, valid, and unrestricted license **Level 3: if not 100%**		12 files
14. Of the 12 credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification **Level 1 @90%**		12 files
15. Of the 12 credentialing files reviewed how many were reviewed for physicians or psychiatrists.		2 files
16. Of the 12 credentialing files reviewed for physician or psychiatrist how many had documentation of residency. **Level 2@90%**		1 file
17. Of the 12 credentialing files reviewed how many board certified physician or psychiatrist had documentation of board certification. **Level 2 @90%**		1 file
18. Of the 12 credentialing files reviewed how many had a copy of a curriculum vitae or a resume. **Level 1 @90%**		12 files
15. Of the 12 credentialing files reviewed how		4 files

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many PHS officers had at least two years of evaluations (COERS). **Level 1 @90%**		
19. Of the 12 credentialing files reviewed how many had current National Provider Data Bank information. (renewable every 2 years) **No IP level**		4 files
20. Of the 12 credentialing files reviewed how many had scope of practice documentation (Pertinent staff only) **Level 1 @90%**		5 files
21. Of the 12 credentialing files reviewed for LIPs how many had a competency assessment or peer review. **Level 2 @90%**		2 files
22. Of the 12 personnel files reviewed, how many contained training folders with HSD-500 record. **No IP level**		12 files
23. Of the 12 personnel files reviewed, how many contained training folders with a signed position description. **No IP level**		*No IP level Observation only for 2018 audits* 12 files
24. Of the 12 personnel files reviewed, how many contained registered nurse training folders reviewed. **No IP level**	12 files	*No IP level Observation only for 2018 audits*
25. Of the RN personnel files reviewed, how many contained registered nurse training folders with RN Physical Exam Training. **No IP level**		7 files
26. Of the 12 personnel files reviewed, how many contained continuing medical education credits. **No IP level**		12 files
27. Of the 12 personnel files reviewed, how many contained BLS for health care providers or CPR and AED certification. **Level 1 @90%**		12 files

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Employee Health Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are employee health files kept separate from other files? (Yes/No) **No IP level**	N/A	YES
2. Is access to employee records limited to the compliance officer, HSA, and AHSA(s) and AA? **No IP level**	N/A	YES
3. Of the twelve-employee health reviewed how many files had past year's TB (PPD or CXR) documentation. **No IP level**		12
4. Of the twelve-employee health reviewed how many files had Hepatitis B vaccination or declination form. **No IP level**		*No IP level Observation only for 2018 audits* 12
5. Of the twelve-employee health reviewed how many files had yearly Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing). **Level 1 @80%**		8 of 8
6. Of the twelve employee health reviewed how many files had yearly respirator medical clearance. **Level 1 @80%**		10 = 83%
7. Of the twelve employee health reviewed how many files had yearly respirator fit test. **Level 1 @80%**		10 = 83%
8. Of the twelve employee health reviewed how many files had with emergency contacts.		Emergency contact info in personnel files
9. Are staff injuries and illnesses documented on the Workforce Injury Tool? **Level 2 @90%**		none in 2018

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Findings/ Recommendations:	Helpful if CTR had more than 1 fit-tester for their staff (which majority are contract staff).
Deliverables:	

Training

Reviewer: CDR Lavalais

Evaluation Method:	Observation		
Items to Review *(Review 12 Files)* ***No IP level****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the twelve training folders reviewed how many had documentation of completed Mandatory ICE Trainings (see guide for list of trainings)			12/12
2. Of the twelve training folders reviewed how many had documentation of completed IHSC Mandatory Trainings(see guide for list of trainings)			12/12
3. Of the twelve training folders reviewed how many had documentation of Completed Emergency preparedness Trainings(see guide for list of trainings)			12/12
4. Of the twelve training folders reviewed how many had documentation of completed Occupational Health Trainings (see guide for list of trainings)			12/12

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5. Of the twelve training folders reviewed how many had documentation of completed TB Management Trainings		12/12
6. Of the twelve training folders reviewed how many had documentation of completed Mental Health Training for Behavioral Health Providers (see guide for list of trainings)		12/12
Findings/ Recommendations:	None	
Deliverables:		

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Schedules

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 3 months Schedules)* *****No IP levels*****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the three month schedules reviewed, how many had a legend to explain codes.			100%
2. Out of the three month schedules reviewed, how many had staff assigned 40 HRS PER WEEK20" per scheduling period. (Refer to guide)			100%
3. Out of the three month schedules reviewed, how many had provider coverage on weekend/holidays.			100%
4. Out of the three month schedules reviewed, how many had actual work hours reflected for non-traditional shifts.			N/A
5. Out of the three month schedules reviewed, how many had signed approvals for non-traditional shifts?			N/A
6. Out of the three month schedules reviewed, how many had a PDF copy each time a change was made to the schedule?			100%
Findings/ Recommendations:			
Deliverables:			

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Summary

Topic	Recommendation
Chronic Care	APPs were directed to complete Special Needs - Med/Psych Alert on all their chronic care
Physical Exams	New MD received additional training from CD on reviewing the chart review bucket to meet th
Segregation	Nursing should review the list of those housed in seg to ensure the daily documentation gets c
MHU Full Adm	MD/APPs need to use the eCW templates. They have been instructed to do so. Nursing shou
Suicide Watch	BHPs need to use the Special Needs for Suicide Observation which includes smock and finge
Hunger Strike	Reviewed the policy with staff at monthly staff meeting. Plan to review policy again at initiatio

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Recommendations from Facility

See above section made by facility (under Summary).

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Additional Comments *(include Section and item number)*

During the 3 months of records reviewed for the pre-assessment, many were notes completed by TDY staff. Although charting practices are standardized through out agency, there were occasional difference in local practices that might have affected our data for this review.

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Deliverables

Topic	Items	Due	Lead
Hunger Strike	CAP for Level 3 finding: Did this hunger strike record have orthostatic	Dec 1, 201	(b)(6); (b)(7)(C)
Suicide Watch	CAP for Level 3 finding: Was a check conducted and documented at l	Dec 1, 201	

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Unit Chiefs and Leadership Review Comment & Feedback

Leadership	Recommendations/ Comments/ Feedback
Chief of Health Operations	
Chief Advance Practice Practitioner	
Chief of PHSP	
Chief of Nursing Services Unit	
Chief of Medical Quality Management	
DAD-Administration	
DAD-Health Systems Support	
DAD Healthcare Compliance	
DAD Clinical Services Review	
Chief Medical Officer Review	
Chief of Staff Review	
AD, IHSC Review	

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Facility:	Reviewers:	Dates:

Chief of Health Operations

_____

Signature

Chief Advance Practice Practitioner

_____

Signature

Chief of Public Health Safety and Preparedness Unit

_____

Signature

Chief of Nursing Services Unit

_____

Signature

Chief Medical Quality Management Unit

_____

Signature

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Facility:	Reviewers:	Dates:

Leadership Signatures

DAD Health Systems Support _____

Signature

DAD Healthcare Compliance _____

Signature

DAD Administration _____

Signature

DAD Clinical Services Review _____

Signature

Chief Medical Officer Review _____

Signature

Chief of Staff Review _____

Signature

AD, IHSC Review Status _____

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
Report generated: undefined

Assessment Information - Report Complete

Facility	San Diego
Site visit start date	2019-06-10
Site visit end date	2019-06-14
Fiscal Year	FY2019
Fiscal Quarter	Q3
Post-audit corrective action identified	Yes
Immediate corrective action identified	Immediate Corrective Action Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Review Complete
DAD, Health Care Compliance Review Status	Review Complete
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Pending Review

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1500
MHU Beds	42
Daily Adult Male Population	1165
Daily Adult Female Population	265
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	121
Facility Information Comments	No corrective actions identified.

Average Number of Encounters (Past 3 Months)

Prescreenings	528
Intake Screenings	524
Physical Examinations	492
Vitals/Labs	586
Sick Call	1224
Pros/Imm	333
Acute	557
Chronic	148
Mental Health	525
Dental	138
Emergent/Urgent	421
MHU	1337
Segregation	857
Admin	237
Transfers	535
Pill-Line Passes	160
Prescriptions (Pill-line + KOP)	1894
Referrals/ER	174

Accreditation - Review Complete

Last ACA Accreditation	2016-11-14T05:00:00Z
Last ACA Findings	No corrective actions identified. ACA will be performing a survey in November. Site reports they are prepared.

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Last NCCHC Accreditation	2017-06-14T04:00:00Z
Last NCCHC Findings	J-G-01 Chronic Disease Services (E). Chronic illnesses are listed on the problem list, and the RHA maintains a list of chronic care patients. The responsible physician establishes and annually approves clinical protocols consistent with national clinical practice guidelines. We confirmed there were guidelines for all nine disease entities. However, the RHA uses Medical Practice Guidelines, dated 2012. We noted that new guidelines have been developed, although there was no documentation of the date that they were implemented. The providers were unaware that they existed, and there was no documentation of any training for them, nor was there documentation to confirm the guidelines are followed. The treatment plans do not include all the appropriate elements; frequency of follow-up, monitoring condition, and status and taking action as indicated, type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medication and adaptation to correctional environment, and clinical justification of deviation from the protocols. The standard is not met. Corrective action is required for Compliance Indicator #1. The responsible physician should establish and annually approve clinical protocols consistent with national clinical practice guidelines. These clinical protocols for the management of chronic diseases should include, but are not limited to, the following: asthma; diabetes; high blood cholesterol; HIV; hypertension; seizure disorder; tuberculosis; sickle cell; and major mental illness. Acceptable documentation includes copies of chronic disease protocols, consistent with national clinical practice guidelines, which have been reviewed and approved by the responsible physician. In order to receive accreditation, verification that this standard has been met is required. Corrective action is required for Compliance Indicator #2. Documentation in the medical record should confirm that clinicians are following chronic disease protocols by determining the frequency of follow-up for medical evaluation based on disease control; monitoring the patient's condition (e.g., poor, fair, good) and status (e.g. stable, improving, deteriorating) and taking appropriate action to improve patient outcome; indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g. diet, medication, exercise); instructing the patient on diet, exercise, adaptation to the correctional environment, and medication; and clinically justifying any deviation from the protocol. Documentation of corrective action should be forwarded to demonstrate that patients receive clinical care that meets national clinical standards. The following is acceptable documentation for compliance: results of a CQI process study that assesses clinicians' compliance in following chronic disease protocols. The CQI study should also include a sufficient number of charts to demonstrate compliance with the standard. In order to receive accreditation, verification that this standard has been met is required. In February 2018, the RHA submitted the results of a CQI study of eight chronic care records (representing the most common conditions from February 14-22, 2018). The records were reviewed for the following criteria: 1) provider determined frequency of follow-up based on disease control; 2) provider noted condition and status; 3) appropriate action taken to improve outcome; 4) provider indicated type and frequency of diagnostic testing and therapeutic regiments (e.g., diet, medication,

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	exercise); 5) documented instruction on diet, exercise, adaptation to correctional environment and/or medication; and 6) documented clinical deviation from protocol. A threshold of 87% was selected. Compliance was demonstrated at 100% in all applicable cases for the first five criteria (the sixth was not applicable in this study). The RHA also submitted a list of guidelines based on national guidelines (such as the Federal Bureau of Prisons), and evidence of provider training in February 2018. Further corrective action is required regarding compliance with the protocols; the study should consist of a sufficient number of examples to demonstrate compliance. It is also recommended that a higher threshold is used to measure compliance. The standard is not met.
Last PBNDS Accreditation	2019-01-23T05:00:00Z
Last PBNDS Findings	No formal findings available by HQ staff preparing this report.
Accreditation Comments	No further action required.

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	10
Of the after hours med log records reviewed, how many records documented the patient's identification number?	10
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	2
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	2
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	No
After Hours Medication Chart Review Findings	Indiviuals pulling medications did not consistently document the detainee's complete name, but the A# was always presents. The count was noted to be off in one drawer because a medication bottle was accidently placed in the wrong pocket. Most of the medications that were pulled from the cart were on the weekends or holidays (primarly after a visit with a provider).
After Hours Medication Chart Review Deliverables	(b)(5)

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	Yes
After Hours Medication Encounters Findings	There were inconsistenties regarding the documentation of the detainee's complete name on the log.
After Hours Medication Encounters Deliverables	See corrective action and deliverable in the section above. No additional actions required.

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	20
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	10
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	10
Of the chronic care records reviewed, how many detainees had psychiatric medications?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	2
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	2
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	3
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	2

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(b)(7)(E)
12/16/2019

Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	20
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	1
Chronic Care Records Findings	There was a failure for patients with chronic care diagnosis to have "global alerts" set.
Chronic Care Records Deliverables	(b)(5)

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	5
Of chronic care encounters observed, how many were considered stable patients?	4
Of the stable patients observed, how many were completed within the appropriate timeframe?	4
Of chronic care encounters observed, how many were considered unstable patients?	1
Of the unstable patients observed, how many were completed within the appropriate timeframe?	1
Of the chronic care encounters observed, how many had a treatment plan?	5
Chronic Care Encounters Findings	The providers did an excellent job educating the patient during the visit. They consistently utilized Up to date during the visit and utilized the teach back methods.
Chronic Care Encounters Deliverables	No CAP or deliverables indicated based on the findings.

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	9
Of the general consent forms reviewed, how many were complete?	9
	16

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Of the consent forms reviewed, how many were dental consent forms?	
Of the dental consent forms reviewed, how many were complete?	16
Of the consent forms reviewed, how many were psychotropic consent forms?	1
Of the psychotropic consent forms reviewed, how many were complete?	1
Consent Forms Findings	No findings. Dental and psychotropic forms were complete
Consent Forms Deliverables	No CAP or deliverables identified on this review.

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	25
Of the daily assignment sheets reviewed, how many were archived appropriately?	25
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	25
Daily Assignment Sheets Findings	Daily assignment sheets were archived to include those with revisions. However, 0/25 assignment sheets were completed fully and are not being used as intended. Areas identified as incomplete include: on-call provider, census, leave/call-outs, workload data. Outdated form being utilized.
Daily Assignment Sheets Deliverables	(b)(5)

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	No
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
	Yes

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Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	
Diagnostic Services Findings	Clia Waived Certificate is expired.
Diagnostic Services Deliverables	1. By Oct 1st, application for CLIA renewal will be submitted. 2. By December 15th, provide RHSA a copy of the active CLIA certificate.

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	After-action report is distributed at the staff meeting. However, there was only a focus on deficiencies. In the future, please addresss both the stregnths, opportunities for improvement and corrective actions planned for implementation. It just needs to be more robust.
Emergency Preparedness and Response Deliverables	(b)(5)

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	No
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes

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Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	Tool Kits are not being used as prescribed.
Environmental Health Deliverables	1, Effective October 1st, ensure all PHSP toolkit inspection lists are utilized and submitted to the HSA for review and signature. 2. By December 15th, provide RHSA copies of the tolkit and evidence that these inspections are reviewed by the HSA.

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	37
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	37
Number of informal grievances.	0
Grievances Findings	Thirty seven formal medical grievances were file in the past three months and 100% were addressed within 5 days. In the past twelve months there were 238 grievances with 10 that were addressed beyong 5 days. Adjustments to the management of the grievance process has improved timeliness. Grievance log follows national policy guidance and grievance officer performs a throurough review of eacah complaint and documentaton shows some complaints have been substantiated. A consistent method of sharing information for substaiated claims was not in place. In an effort to use this data for CQI initiatives, instructed grievance officer to share finding with the FHPM and local administrators. Grievance officer immediately acted on guidance and most recent substantiated claim was forwarded and corrective action is actively being worked on.
Grievances Deliverables	(b)(5)

Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	2
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	0

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Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	2
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	2
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	2
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	0
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	0
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	1
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	2
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	1
Hunger Strike Records Findings	1) Detainee refused having vitals signs taken (including orthostatic vitals), hunger strike assessment and I&O 2) Only one of the two charts the hunger strike was discontinued by the CD; however the APP did document that the CD was informed of the case/discharge plan. 3) For one of the two cases the detainee was simultaneously on Suicide Watch/Precautions while on Hunger Strike; special needs for finger foods only was noted but not one for restriction of commissary items; however suicide precaution special needs would trump hunger strike special needs orders. So I did not ding them for not having restrictions of commissary items special needs form completed.
Hunger Strike Records Deliverables	(b)(5)

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	1

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Of the patients on a hunger strike, how many was water available for?	1
Of the patients on a hunger strike, how many were offered meals?	1
Of the patients on a hunger strike who were offered food, how much food was offered?	1
Of the food offered, how much of the food was eaten?	1
Of the patients on a hunger strike, how many had special needs?	1
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	1
Hunger Strike Encounters Findings	Staff did a great job at considering the detainee's religious beliefs as it relates to food.
Hunger Strike Encounters Deliverables	No CAP or deliverables indicated.

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	No
Infectious Disease Prevention Findings	No evidence of hand hygiene monitoring for the January-March 2019 timeframe.
Infectious Disease Prevention Deliverables	(b)(5)

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	8
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	8
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	17
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
	0

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Of the intake screen records reviewed, how many records had a pain scale greater than 0?	
Of the records with a pain scale greater than 0, how many were assessed?	0
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	8
Of the intake records with clinically significant findings, how many were referred appropriately?	8
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	16
Intake Screen Records Findings	No process failures identified on the intake chart review.
Intake Screen Records Deliverables	No CAPS or deliverables required.

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	8
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	3
Of the intake screen encounters observed, how many included a full set of vital signs?	8
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	3
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	3
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	3
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	0
Intake Screen Encounters Findings	Two staff assessed. The TDY nurse performed the intake questions using the template and asked 100% of questions and provided the required pt education. The local nurse relied on memory and asked numerous questions combined into one generic question which did not meet the intent of the intake. The pre-screening was not reviewed prior and no education to the upcoming scheduled PE. RN stated that it confused the patients especially when they run behind on PEs. Nurse documented responses to 100% of the questions on intake although she only recieved resposes to 40%. No patienys screened has any identified special needs.
Intake Screen Encounters Deliverables	(b)(5)

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(b)(5)

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	4
Of the language access records reviewed, how many did not use a translator?	21
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	21
Language Access Records Findings	Of the 25 records reviewed, four (4) documented use of a translator. For the 21 records that did not document use of a translator, they each contained a reason why the translator was not utilized. None of the 25 charts reviewed were out of compliance for language access.
Language Access Records Deliverables	No CAPS or deliverables required.

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	During the onsite review "I speak" posters were present along with the language interpreter call information visible throughout the clinic. During patient encounters ensure providers are asking patients their language of preference and offer the use of the interperter line. Also, consider an ask back method to determine if an interpreter line is needed.
Language Access Encounter Deliverables	(b)(5)

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Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	10
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	10
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	Yes
Log Books Findings	Of the pharmacy refrigerator temperature logs reviewed, the facility only has one shift. Reviewed 10 logs from January-May, 2019.
Log Books Deliverables	No CAPS or deliverables indicated.

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	15
Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	15
Of the medication administrations observed, how many mouth checks were conducted?	15
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	15
How many MAR entries were observed?	10
Of the MAR entries observed, how many were complete?	10
Of the MAR entries observed, how many medication refusals were documented?	1
	1

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Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	
Of the identified medication refusals, how many were high-risk medications?	1
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	1
Medication Administration Findings	Medication administration followed all practices associated with the safe delivery of medication. Mouth checks are performed routinely and documentationperformed in real-time. Refusal forms completed as patients refused medications and chart review performed to alert provider. Patient refusing psychotropic medications had an appointment next day with (b)(6); (b)(7)(C)
Medication Administration Deliverables	Incidental findings which crossed several clinical areas: patient identification typically lacked patient involvement and rested soley on agreeing with their name and highly reliant on the patient's ID. Recommend retrain and monitoring to ensure active patient participation in the ID process (have patient verbalize one identifier: name, DOB or A#). No CAP or deliverable required.

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	0
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	1
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	Staff meeting minutes documented appropriately for last two months. Some information was "rolled" from meeting to meeting recommend fresh info at each meeting to ensure current issues are highlighted. No health and safety meeting minutes available. Local CQI meeting held in April, but no meeting minutes documented. Previous CQI meeting minutes well documented and included the national meeting minutes. ICE/PHS meeting present, but do not include all of the elements required by NCCHC.
Meetings Deliverables	(b)(5)

MHU Full Admission Chart Review - Review Complete

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How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	14
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	18
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	7
Of the MHU full admission records reviewed, how many had a nursing care plan?	16
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	2
Of the MHU full admission records reviewed, how many had patient education provided daily?	8
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	7
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	5
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	18
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	18
MHU Full Admission Records Findings	1) The charts were difficut to review. I found out that they have two different types of MHU's. An actual MHU and then an MHU dorm, which was confusing because the Provider notes didn't have any Admission or Discharge notes stating which MHU is being used. Also I wasnt sure of their process or if the same standards apply for both types of MHU's. MHU Dorm Status has little or no charting only RN 24 hr chart reviews for most charts and no provider discharge notes. Only one Provider order stated "step down to the MHU Dorm, visits and vitals per nursing protocol" 2) "Reason" section frequently did not list MHU Admission or Dischrage, making it difficult to know which chart to review.
MHU Full Admission Records Deliverables	(b)(5)

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MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	25
How many patients are in the MHU full admission at the time of observation?	25
How many MHU full admission patients have a 24-hour chart review everyday?	25
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	25
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	25
MHU Full Admission Encounters Findings	No data reported
MHU Full Admission Encounters Deliverables	No data reported

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	11
Of personnel and credentialing files reviewed, how many were PHS officers?	8
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	1
Of personnel and credentialing files reviewed, how many were federal civil service employees?	0
Of personnel and credentialing files reviewed, how many were contractors?	3
Of personnel and credentialing files reviewed, how many records are for privileged staff?	4
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	2
Of the LIP staff records reviewed, how many had personnel files records current?	2
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	2
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	10

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Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	10
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	10
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	8
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	10
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	10
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	8
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	0
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	10
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	3
Of the staff records reviewed, how many had scope of practice documentation if applicable?	1
Personnel and Credentialing Files Findings	Overall, the personnel and credentialing files were well organized. An excel tracking system is used to track all staff members. The newest staff member's (arrived in April 2019) file was partially complete. Signed statement of acknowledgement of understanding of local, etc. were not documented in the same location. In addition, PE competencies are not signed off on. No, plan in place to ensure completion. Two years of PHS COERs are not present. Scope of practice documentation not present.
Personnel and Credentialing Files Deliverables	(b)(5)

Physical Exam Chart Review - Review Complete

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How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	9
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	9
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	11
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	8
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	1
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	3
Of the physical exam charts reviewed, how many were for adult females?	6
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	6
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	6
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	6
Physical Exam Records Findings	25 Charts were reviewed. Language line was used for 9 and documented properly. Providers were fluent in the languages used by the other 16 detainees. The facility does not house children. 11 of the physical exams were PE simples. They were done within 14 days of arrival. 14 required PE complexes. All 25 had pain assessments. 8 had pain and the pain was addressed. 1 PE C was reviewed by MD within the specified 7 days. 3 PE S' were reviewed by MD with 14 days. 4 records were not reviewed by MD. Many of the records had a MD review but were past the specified time of 7 days for PE C's and 14 days for the PE Simples. 6 of the 25 were females. Menstrual cycles were documented for all. None of the females required paps. The audit tool asks if PE simples were done within 14 days. There is not a question asking if PE complexes were done within 2 days.
Physical Exam Records Deliverables	No corrective action at this time. (b)(5)

(b)(5)

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Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	10
Of the physical exam encounters observed, how many included a full set of vital signs?	10
Of the physical exam encounters observed, how many were completed within the specified timeframe?	10
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	1
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	1
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	10
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	10
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	0
Physical Exam Encounters Findings	Facility is working ahead of schedule on PEs as time permits - proactive measure incase of large influx of patients. Best practice! All questions are not being asked as outlines in the PE templates; poses risk for incorrect/faulty history. Encourage staff to follow questionairre as outlined to ensure the best history possible. There were no PEs that required a referral to a higher level of care.
Physical Exam Encounters Deliverables	(b)(5)

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	14
Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	Yes
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	14
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	6
Prescreen Encounters Findings	Observations occurred with only one staff member (TDY from HQ). No findings or recommendations.

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Prescreen Encounters Deliverables	No corrective actions or deliverables indicated.

Risk Management - Review Complete

Trends	No RM trending data to review.
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	0
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0
List all corrective actions identified in the preceding field and note their status and due dates.	N/A
Risk Management Findings	No data analysis of IRs.
Risk Management Deliverables	(b)(5)

Schedules - Review Complete

How many schedules were reviewed?	3
Of the schedules reviewed, how many had a legend to explain codes?	3
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	2
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	3
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	3
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	Schedule maintainance/revisions are not performed timely. The schedules most probably do not reflect actual hours worked by employees. No systematic process to revise schedule as changes are made. Officer reflected as attending CME was actually on AL. These are incidental findings and will be addessed by RHSA on-site.
Schedules Deliverables	(b)(5)

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Segregation Chart Review - Review Complete

How many segregation records were reviewed?	0
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	0
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	0
Of the segregation records reviewed, how many offered the patient daily sick-call services?	0
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	0
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	0
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	0
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	No data reported
Segregation Records Findings	No segregation records were found with 90 days
Segregation Records Deliverables	No CAP or deliverables required.

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	0
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	No data reported
Segregation Encounters Findings	No data to review.
Segregation Encounters Deliverables	No CAP or deliverables required.

Shift Report and Time Cards - Review Complete

Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	No

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Shift Report and Time Cards Findings	Changes are made to timecards without HSA or AHSAs signature. Multiple timecards are used throughout a reporting period for staff.
Shift Report and Time Cards Deliverables	Ensure timecards with changes are verified. No CAP or deliverables required.

Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	2
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	2
Of the sick call records reviewed, how many included a full set of vital signs?	25
Of the sick call records reviewed, how many had a pain scale greater than 0?	6
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	6
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	24
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	24
Of the sick call records reviewed, how many had the reason for visit from an approved category?	24
Of the sick call records reviewed, how many were addressed by a nurse?	25
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	No data reported
Sick Call Records Findings	Review met thresholds.
Sick Call Records Deliverables	No CAP or deliverables required.

Staffing Information - Review Complete

(b)(7)(E)

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(b)(7)(E)

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(b)(7)(E)

Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed?	13
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	13
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	9
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	8

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Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	13
Of the suicide watch records, how many had a patient released from suicide watch?	13
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	13
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	13
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	13
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	7
Suicide Watch Pre-Audit Findings	4 of 13 were missing special needs for suicide smock 5 of 13 were missing special needs for finger foods 6 of 13 were missing the 15 min checklist
Suicide Watch Pre-Audit Deliverables	(b)(5)

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	1
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	1
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	1
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	1
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	1
Suicide Watch Encounters Findings	No significant findings.
Suicide Watch Encounters Deliverables	No CAP or deliverables required.

Training - Review Complete

How many training folders were reviewed?	12
Of the training folders reviewed, how many had a HSD-500?	11

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Of the training folders reviewed, how many had a signed position description ?	10
Of the training folders reviewed, how many were registered nurse training folders?	6
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	2
Of the training folders reviewed, how many had continuing medical education credits documented?	6
Training Findings	HSD- 500 was signed within 3 days. It is a best practice to have the dates reflect the actual date of orientation. Continung educ - PALMS CDR [redacted] - No HSD-500 filed - in progress; no RN training [redacted] - PD present unsigned Wocom - PE Assessment expires 06/17 [redacted] - expired PE assessment 05/18 [redacted] - PE training expired 02/19
Training Deliverables	(b)(5)

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	25
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	25
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	0
Transfers Findings	Ensure that the Problem List represents the Transfer Summary
Transfers Deliverables	No CAP or deliverables required.
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	23
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	10

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Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	12
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	12
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	0
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	9
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	9
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	No
Workforce Health Files Findings	A detailed table of content is used to list all requirements and date in which the requirement is completed. The table of content is updated annually by erasing previous date and inputting new date (in pencil). Ishihara color blind test is conducted during onboarding; not conducted yearly. Workforce Injury Tool is not in use.
Workforce Health Files Deliverables	(b)(5)

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Leadership Review

Facility	Stewart
Start Date	2017-11-06
End Date	2017-11-10
Status	Leadership Review
Corrective Action Required?	Yes
On-Site Corrective Actions	Immediate Corrective Action Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Pending Report Completion
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Pending Report Completion
DAD, Health Care Compliance Review Status	Pending Report Completion
DAD, Health Systems Support Review Status	Pending Report Completion
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Pending Report Completion

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	2042.00
MHU Beds	5.00
Daily Adult Male Population	1976.00
Daily Adult Female Population	0.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	58.34
Comments	NO DATA

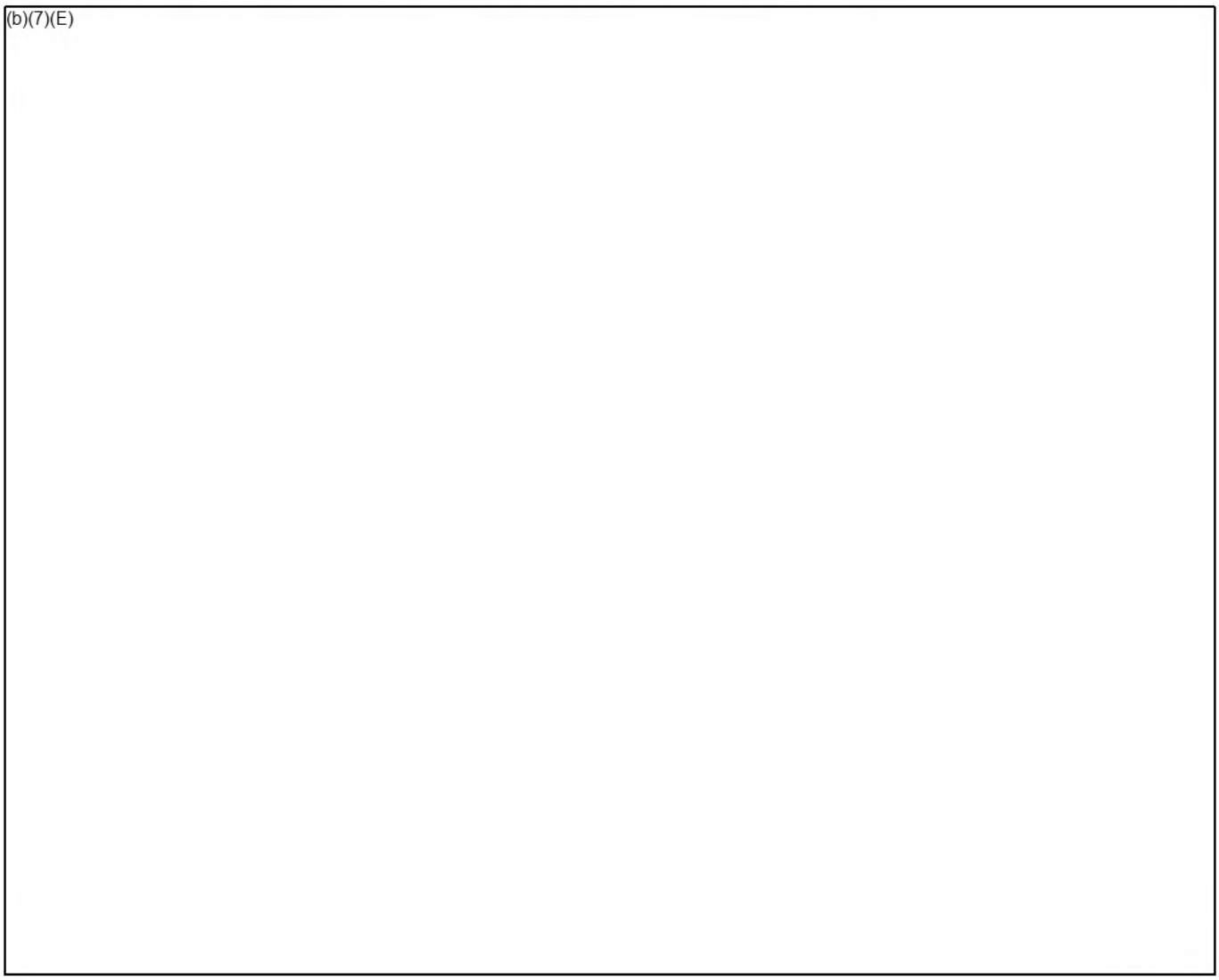
Average Number of Encounters (Past 3 Months)

Prescreenings	1187.00
Intake Screenings	1155.33
Physical Examinations	415.67
Vitals/Labs	1645.00
Sick Call	1118.67
Pros/Imm	1.00
Acute	255.67
Chronic	179.00
Mental Health	284.67
Dental	141.33
Emergent/Urgent	28.30
MHU	754.67
Segregation	528.33
Admin	72.30
Transfers	1090.67
Pill-Line Passes	656.00
Prescriptions (Pill-line + KOP)	24870.33
Referrals/ER	172.67
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)



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Accreditation - Review Complete

Last ACA Accreditation	2015-06-01
Last ACA Findings	Last ACA survey June 2015; Compliant with 100% of all applicable mandatory standads; 98.7%of non-mandatory standards.
Last NCCHC Accreditation	2015-04-08
Last NCCHC Findings	Stewart's initial NCCHC survey was conducted April 8-9, 2015. They were found compliant with 100% of all applicable mandatory standards, and 100% of all applicable non-mandatory standards. They had no corrective action to respond to.
Last PBNDS Accreditation	2017-05-02
Last PBNDS Findings	No medical findings.
Comments	NO DATA

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Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	24.00
Is there a local SOP for managing grievances?	No - See findings below.
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	No - See findings below.
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	38.00
Number of informal grievances.	0.00
Findings	No local grievance procedure. Collateral duty assigned to AHSA via appointment letter. Local grievances were routinely managed in less than 5 days. There were two outliers; one pt released prior to the grievance being addressed and and one hospitalized (unavailable). Several of the grievances were founded and corrective action implemented. Electronic log book not up to date - due to transition of responsibilities and current orientation to new duties. HSA will correct on the spot. Encouraged HSA to direct new Grievance Officer to read IHSC policy to enhance understanding of requirements and implement and additional local requirements (LOP).
Deliverables	Develop grievance LOP

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Risk Management - Review Complete

Trends	1 active RCA pending due to mortality. Awaiting finalization of CAP portion at this time.
Number of active RCAs/SOEs	1.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	NO DATA
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	No - See findings below.
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	6.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	3.00
Number of high risk medication refusals.	3.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	3.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	Staff reports that refusal forms from pill-line yesterday are pending to be documented in eCW - "I will chart it as a late entry". Uncertain if this is a routine practice. On two occassions mouth checks were not performed. MARs were documented well no "holes" in MARs, signatures well docuimented. Refusals only documented in eCW on 3/6 occassions. Documentation consisted of "medication refused" in telephone encounter. No specific information regarding the refusal or type of medication refused included in the documentation. Refusal forms are incomplete and pose an opportunity for improvement.
Deliverables	(b)(5)

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(b)(5)

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	No - See findings below.
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	No - See findings below.
Are all staff trained on emergency equipment?	No - See findings below.
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	No - See findings below.
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	Annual Mass Casualty was 13FEB17 Write-ups are missing for several months to properly verify man-down drills and Fire Drills are being done. Could not verify all staff participating due to missing write-ups/documentation. Currently drills are done during shift change times to capture two shifts each drill per administration. Recommend AAR/After Action Debriefing be documented on drill write ups. Need to keep records of staff training on emergency equipment/documentation Recommend updating the call tree with current staff.
Deliverables	(b)(5)

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Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	No - See findings below.
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	No - See findings below.
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	SDS is not current. Per HSA, Core Civic is responsible for maintaining SDS at the facility. For items deficient in PHSP checks, need to document corrective action completion date.
Deliverables	(b)(5)

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	6.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	6.00
Number of psychotropic consent forms among the identified consent forms.	7.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	7.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	6 out of the 7 detainees with psychotropic consent forms had consent forms from stewart. 1 detainee A (b)(6); (b)(7)(C) (transferred from Krome to Stewart due to hurricane), had a psych form from Krome
Deliverables	NO DATA

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	22.00
Out of the transfers reviewed, how many had a positive chest X-ray?	8.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	5.00
Out of the transfers reviewed, how many have active TB?	0.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	10.00
Number of transfers with medication instructions clearly provided.	10.00
Number of transfers signed by a proper level provider.	25.00
Findings	Out of the 25 transfer summaries reviewed 8 were being treated empiricly for TB. TB r/o (b)(6); (b)(7)(C) - Progress note unlocked and TB medications ordered for transfer, but not listed on transfer summary. Transfer summary indicated that the TB-CM case report was attached, but most recent report indiated smear and culture results pending, therefore providing no labs indicating non-infectiousness. TB r/o (b)(6); (b)(7)(C) Transfer summary indicated that the TB-CM case report was attached, but most recent report indicated that lab samples were rejected and new labs were ordered. TB r/o (b)(6); (b)(7)(C) Progress note unlocked; TB r/o (b)(6); (b)(7)(C) Transfer summary indicated that the TB-CM case report was attached, but most recent report indiated smear and culture results pending, therefore providing no labs indicating non-infectiousness.

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Deliverables	NO DATA

Prescreening Review - Review Complete

Number of prescreens reviewed.	24.00
Number of prescreens with detainee identified with at least two detainee identifiers.	24.00
Number of prescreens triaged according to prescreen policy.	22.00
Number of prescreens that used a translator.	11.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	11.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	0.00
Number of prescreens with documentation completed in eCW prior to intake screening.	0.00
Findings	Twenty-five (25) charts were pulled. Out of those 25, one did not have pre-screening documentation included. Therefore, 24 pre-screens were reviewed. Out of 24 pre-screens reviewed, 22 were triaged per pre-screening policy (with a priority level listed). Two pre-screenss did not document a priority level. Out of the 13 pre-screens where a translator was not utilized, nine (9) documented a reason for not utilizing a translator. Four (4) did not document a reason for not utilizing a translator.
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	4.00
Number of prescreen encounters observed that allowed for patient privacy.	4.00
If privacy was not provided, where was the prescreen performed?	RN used space/distance to afford for privacy. RN did not use questionairre to perform pre-screen. Pre-screen performed after 1.5 hours of being in the facility. Communication between intake officer and clinic coordinator occurred, but clinic coordinator had delays in identifying an individual to perform the pre-screen. Language services should have been utilized as one individual reported that they spoke "little english" and an interpretoir was not secured.
Number of prescreen encounters that used language services.	0.00
Number of prescreen encounters completed within two hours of arrival.	4.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	4.00
Number of prescreen encounters prioritized.	4.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	4.00
Findings	RN used space/distance to afford for privacy. RN did not use questionairre to perform pre-screen. Pre-screen performed after 1.5 hours of being in the facility. Communication between intake officer and clinic coordinator occurred, but clinic coordinator had delays in identifying an individual to perform the pre-screen. Language services should have been utilized as one individual reported that they spoke "little english" and an interpretor was not secured.
Deliverables	(b)(5)

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	19.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	19.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	6.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	23.00
Of the intake screening records, how many were TB negative?	23.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	2.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	0.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	0.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	7.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	6.00
Number of intake screenings reviewed by an RN or above within 24 hours.	0.00
Findings	Of the 25 Intake charts reviewed, 23 had TB clearance or documentation. Two (2) had no TB documentation in the medical record (i.e. no TB clearance noted under the Scanned Docs, Labs, etc tabs of e-CW). Of the 23 Intakes with TB documentation/clearance, two had TB records which were signed, dated and stamped by a RN or higher. Of the 25 intake screenings reviewed, seven (7) had clinically significant findings. Of those, six were referred appropriately. On one intake screening, as to the question of whether they had any signficant dental problems, the detainee indicated they had a chipped tooth in the front of their mouth. There was no documentation discovered on the intake screening, that the issue was addressed via a referral to dental or other mechanism. Of the 25 intake screenings reviewed, nine (9) of them were conducted by a LVN or LPN, thus requiring confirmatory sign-off by a RN or higher within 24 hours. Of those 9 intakes conducted by a LVN or LPN, zero were in compliance with this requirement. Four (4) were lacking any documentation/evidence of a confirmatory sign off. Of the remaining five: The intake screening was conducted on August 7; confirmatory sign-off was done on October 30. The inake screening was conducted on October 10; confirmatory sign-off was October 30. Intake screening was conducted on September 6; confirmatory sign-off was on October 30. Intake screening was conducted on September 18; confirmatory sign-off was on October 30.
Deliverables	NO DATA

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Intake Screening Observations - Review Complete

Number of intake screenings observed.	5.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	5.00
Number of intake screening observations where a full set of vital signs were taken.	5.00
Number of intake screening observations that used language services.	3.00
Of the intake screening observations that used language services, how many were appropriately conducted?	3.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	5.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	3.00
Number of intake screening observations with security advice of special needs and housing disposition.	5.00
Of the intake screening observations with security advice, how many contained clear communications?	5.00
Findings	Grievevance process education was not observed to occur with 2 patients
Deliverables	Educate all patients on the grieveance process

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Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	25.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	24.00
Number of chronic care encounters with medications.	17.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	17.00
Number of chronic care encounters with psychiatric medications.	1.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	1.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	1.00
Number of chronic care patients identified as stable.	24.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	0.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	1.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	8.00
Findings	NO DATA

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Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	5.00
Number of chronic care encounters observed that utilized language services.	0.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	5.00
Findings	NO DATA
Deliverables	NO DATA

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	25.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	25.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	1.00
Of the physical examinations with pain assessment, how many were addressed?	1.00
Number of physical examinations with clinically significant findings.	25.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	25.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	24.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	NO DATA
Deliverages	NO DATA

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Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	1.00
Number of physical examination encounters with a full set of vital signs taken.	1.00
Number of physical examination encounters observed that were completed within 14 days.	1.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	Physical exam was not performed in a systematic manner. Physical assessment performed before the history and was not performed from head to toe. Patient complained of sore throat and throat visualized but neck not assessed. Extensive musculoskelatal exam performed, but not required as much of what was assessed could be observed by the patients ability to walk, sit and stand. EYes were not assessed. Area being used did not allow for palpation of the abdomen. OTC medications were provided for the patients complaint, but the medications and labels were disorganized making it very inefficient. Many areas of preventative health education were provided, but RN failed to educate the patient on what tthe S&S related to his medical complaint would necesitate his return for further evaluation. Told the patient if he did not take CTM and nasal spray as dtrected that "an infection could go to his brain." She also informed the patient that he needed to have some teeth pulled- no within the rNs scope of practice.
Deliverables	(b)(5)

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(b)(5)

Sick Call Review - Review In Progress

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	7.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	4.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	24.00
Number of sick call encounters with a pain scale greater than 0.	14.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	10.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	17.00
Number of sick call encounters where the reason is documented in the "Reason" field.	21.00
Number of sick call encounters where the reason for the visit was from an approved category.	17.00
Number of sick call encounters addressed by a nurse.	24.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	24.00
Findings	NO DATA
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	No - See findings below.
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	N/A - See findings below.
Findings	Patients in segregation are offered sick call during seg rounds and seen/evaluated in/through the seg window or room if s/c is managed by RN. If seg sick call request is elevated to a MLP then the detainee is taken to medical. Appropriate equipment/setting/access to language services should be afforded to all individuals. New process for sick call implemented. Appears to be effective. However, it is noted that a high percentage of individuals who request sick call through security and up being a "no show" when sick call is initiated. Evaluate cause of "no shows" to ensure adequate access to care and seek guidance from Chief Nurse if these "no shows" should actually be considered "refusals". No team approach to accomplish sick call; HSA will revisit when renovations occur and more space is available.
Deliverables	NO DATA

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MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	12.00
Number of MHU 23 hour observation records with discharge encounters.	11.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	13.00
Number of MHU 23 hour observation records with telephone order admission.	7.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	6.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	1) (b)(6); (b)(7)(C) Detainee placed in MHU upon intake for declaring hunger strike (transfer summary also indicated that the detainee had been on hunger strike x 21 days); no documentation that on site or on call provider was notified so no telephone orders is noted for a verbal order to place detainee in MHU; No MHU Admission note/orders documented also 2) (b)(6); (b)(7)(C) MHU Admission orders via Telephone encounter; MHU Admission note not labeled/identified and MHU Admission template not utilized; (b)(5) (b)(5)
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	No - See findings below.
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	5.00
Number of MHU full admission records reviewed.	25.00
Number of MHU full admission records with admission encounters.	10.00
Number of MHU full admission records with discharge encounters.	16.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	25.00
Number of MHU full admission records with no PE within the past year.	7.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	7.00
Number of MHU full admission records with acuity level assigned.	3.00
Number of MHU full admission records with all medications placed on pill line.	16.00
Number of MHU full admission records with 24 hour chart reviews everyday.	25.00
Number of MHU full admission records for patients in segregation for medical overflow.	11.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	11.00
Number of MHU full admission records with a nursing care plan.	25.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	25.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	25.00

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Number of MHU full admission records with mental health diagnoses.	6.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	6.00
Number of MHU full admission records without mental health diagnoses.	19.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00
Findings	1) MHU admission and discharge notes are not being labeled/identifiable; MHU and discharge templates were not utilized therefore no acuity level was assigned. 2) physical exam never completed the entire time detainee was in custody and admitted to the MHU (b)(6); (b)(7)(C) 3) Several of the cases the detainees were housed in Segregation for MHU/Medical Overflow; they were rounded on daily per MHU policy 4) previously ordered KOP medications should be discontinued and re-ordered as pill line upon MHU admission (this was not reflected in eCW for several cases) 5) Serveral MHU admission encounter/orders were via telephone encounter even though the detainee was seen by the provider and the MHU admission template was not utilized 6) Except for rescue inhalers and NItro all medications should be ordered Pill line upon MHU admission (per the chart reviewed only the RIPE Therapy medications and the Psych medications were ordered as Pill line and all other medications were being ordered as KOP upon MHU admission) 7) some cases the MHU discharge note by a proivder is missing altogether 8) for (b)(6); (b)(7)(C) on 10/2/17 MLP documented MHU Provider rounds for detainee in segregation, detainee was not present during the encounter due to being out on recreation yard but discharged the patient without seeing him
Deliverables	NO DATA

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Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	6.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	5.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	5.00
Number of suicide watch records where the need for finger foos was annotated.	6.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	6.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	5.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	5.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	2.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	2.00
Findings	Nursing rounds documented, but some rounds were documented as grater than 8 hours.Custody forms are not consistently scanned into charts.
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	No suicide watches at time of site- visit. Initially instructed that there was one suicide watch; it was later determined that the individual was not on and suicide prevention interventions. Recommend that there is better communication regarding the type of "watch" an individual is placed on in the MHU.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Hunger Strike - Review Complete

Number of hunger strike records reviewed.	6.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	4.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	3.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	2.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	1.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	3.00
Number of hunger strike records with special needs.	1.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	1.00

Findings

(b)(5)

Deliverables

NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	25.00
Number of segregation records where daily segregation rounds by nursing are documented.	25.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	25.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	4.00
Number of segregation records where the patient was seen weekly by mental health.	24.00
Findings	1) overall good segregation documentation; segregation clearance noted for all of the charts reviewed; only 1 chart noted to have a daily RN seg round encounter missing (b)(6); (b)(7)(C) on 9/27/17) 2) 4 charts were noted where the detainee was in Segregation longer than 30 days and the 30 days mental health status was evaluated 3) 24 cases were seen weekly by mental health; 1 case the detainee was in seg in less than a week therefore no weekly MHU seg round encounter was noted. Of the 24 charts that had the weekly MHU Seg round notes completed there were 2 cases where the weekly MHU Seg round was missing. (b)(6); (b)(7)(C) MH Seg encounter on 10/4/17 and the next one isn't until 10/18/17) (b)(6); (b)(7)(C) MH Seg round on 9/13/17 and next one wasn't until 9/26/17)
Deliverables	NO DATA

AMERICAN OVERSIGHT

After Hours Medication Review - Review Pending

Number of after hours medication records reviewed.	0.00
Number of after hours medication records with the patient's identification number documented.	0.00
Number of after hours medication records with medication order(s) documented in eCW.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order.	0.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	0.00
Does the pharmacy have a reconciliation process?	NO DATA
Does the pharmacy follow the reconciliation process?	NO DATA
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	No - See findings below.
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No - See findings below.
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	No - See findings below.
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	After hours cabinet nicely stocked and organized. Accountability log is present, but does not have an area to identify quantity removed or added to stock. Providers are not routinely following procedures as it relates to accountability of medications. The quarterly pharmacy audit demonstrated significant discepancies, but no documentaed action taken.
Deliverables	(b)(5)

AMERICAN OVERSIGHT

Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	25.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	25.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	17.00
Reasons for why a translator was not used.	Twenty-five Intake charts were reviewed for Language Access purposes. Of those 25: All 25 documented the patient's primary language. Of the 25, 17 documented use of an interpreter, including the interpreter name and number. Of the remaining six, all documented a reason for an interpreter not being utilized. The reasons were: Not applicable, patient speaks English No, provider fluent in patient's native language On one chart, there was an apparent discrepancy between the Pre-screening and Intake screening documentation, regarding use of an interpreter. On this particular detainee, the same RN conducted both the pre-screening and the intake screening. For the pre-screening, the RN documented no interpreter was utilized because "provider fluent in detainee's native language." However, the intake screening indicates interpretation was provided and lists the interpreter's number.
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	No - See findings below.
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	No - See findings below.
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	No - See findings below.
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	N/A - See findings below.
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	Need local operating procedures for all CLIA processes and staff were not knowledgable on what CLIA meant. This should be part of each nurse's orientation.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	3.00
Number of refridgerator temperature logs that are up to date.	3.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	No - See findings below.
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	Yes
Findings	Keys and scissors were not signed out; count not accurate. Staff acknowledges that it can be challenging at times to get staff tpo comply with known performance elements.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	12.00
Number of daily assignment sheets completed and archived .	12.00
Number of daily assignment sheets with one emergency team identified per shift.	10.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	9.00
Number of daily assignment sheets with clinic inspection completed and signed.	0.00
Are detainee referrals documented?	Yes
Findings	Daily assignment sheets are kept electroniclly. Assignments are also written and updated daily on dry erase board in clinic. Only 12 daily assignment sheets were reviewed online. System was also slow. Facility does not maintain a binder of hard copies. Call outs/scheduling changes not properly documented on daily assignment sheet on 3. Emergency teams not filled out for 2 sheets. Daily clinic inspections completions were missing on all sheets; although already completed as part of PHSP.
Deliverables	(b)(5)

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Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	No - See findings below.
Findings	Written entries on the time card are not always signed of by the HSA or designee. Time verified through teh camera.
Deliverables	NO DATA

Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	1.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	0.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	Staff meetings minutes are e-mailed to all staff. Recommend sign off sheet concerning reading and acknowledgement of staff meeting minutes monthly. Facility is not currently doing quarterly PHSP and QI meetings quarterly
Deliverables	(b)(5)

AMERICAN OVERSIGHT

Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	5.00
Number of federal civil service employee personnel files reviewed.	0.00
Number of contractor personnel files reviewed.	7.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	Yes
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	5.00
Of the personnel file records for priveleged staff, how many are current?	5.00
Number of personnel files with current and signed Health and Ability form.	12.00
Number of personnel files with a signed statement of confidentiality (one time).	12.00
Number of personnel files with a signed statement of risks and responsibility (one time).	12.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	12.00
Number of personnel files with a signed release of information form (one time).	12.00
Findings	Nursing competencies and scope of practice were not current in all files evaluated. Recommend that the PD is initialed and dated along with the signed acknowledgement of reciept of said document.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	0.00
Number of federal civil service employee credentialing files reviewed.	0.00
Number of contractor credentialing files reviewed.	3.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	3.00
Number of credentialing files with current, valid, and unrestricted license.	3.00
Number of credentialing files with license primary source verification.	0.00
Number of credentialing files with documentation of primary education.	3.00
Number of credentialing files with education primary source verification.	3.00
Number of credentialing files reviewed for physicians or psychiatrists.	1.00
Number of physician or psychiatrist credentialing files with documentation of residency.	1.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	1.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	1.00
Number of credentialing files with a curriculum vitae or resume.	3.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	0.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	3.00
Number of credentialing files with scope of practice.	0.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	0.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	3.00
Number of peer reviews reviewed.	3.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	3.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	Credential files reviewed for 3 of 4 LIPs. All credential folders complete. Licensure is not primary sourced verified - Corrected on the spot. Informed that AA does does look up each license on-line to verify, but no process in place to document that it was actually performed. Corrective action will be taken to improve process and HSA will secure priveldge letter or initiate priveldging application.
Deliverables	NO DATA

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	10.00
Number of employee health files with current TB (PPD or CXR) documentation.	10.00
Number of employee health files with current Hepatitis B vaccination or declination form.	10.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	10.00
Number of employee health files with current respirator medical clearance.	10.00
Number of employee health files with current respirator fit test.	10.00
Number of employee health files with emergency contacts.	0.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	Yes
Findings	Employee emergency contacts are maintained electronicallty and in a paper binder. Encouraged HSA to place Emergency Contact information in the healtjh records to ensure that PII is not left in unsecured areas.
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	11.00
Number of training folders with HSD-500.	11.00
Number of training folders with a signed position description.	11.00
Number of registered nurse training folders reviewed.	3.00
Number of registered nurse training folders with RN Physical Exam Training.	3.00
Number of training folders with continuing medical education credits.	11.00
Number of training folders with BLS for health care providers or CPR and AED certification.	11.00
Number of radiation safetoy officer training folders with radiation safety training.	0.00
Findings	Facility keeps the HSD 500 in personnel files. HSA attended Radiation Safety Officer training; awaiting certificate
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	No - See findings below.
Findings	Hand Hygiene monitoring is not currently conducted and documented. HSA is aware and will initiate monitoring and documentation.
Deliverables	Hand Hygiene monitoring and documentation.

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	0.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	No - See findings below.
Findings	The MLP schedule is not consistent with the "level" of providers from day to day. Cuurrently utilizing self-scheduling and guiding staff to develop a schedule that is a mix between level scheduling and operational needs. HSA was aware of the opportunity for improvement and is actively working towards that end. No corrective action indicated, but RHSA may want to follow-up. Archiving process is not maintained as each schedule is modified. HSA advised and will make the required changes.
Deliverables	NO DATA

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	Tacoma
Start Date	2017-03-12
End Date	2017-03-17
Status	Report Complete
Corrective Action Required?	Pending Determination
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Complete
Chief of Staff Review Status	NO DATA
AD, IHSC Review Status	Review Deferred (Team Lead Only)

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1575.00
MHU Beds	9.00
Daily Adult Male Population	1337.00
Daily Adult Female Population	154.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	120.00
Comments	NO DATA

Average Number of Encounters (Past 3 Months)

Prescreenings	480.00
Intake Screenings	453.00
Physical Examinations	356.00
Vitals/Labs	149.00
Sick Call	706.00
Pros/Imm	54.00
Acute	310.00
Chronic	122.00
Mental Health	342.00
Dental	256.00
Emergent/Urgent	182.00
MHU	620.00
Segregation	638.00
Admin	152.00
Transfers	472.00
Pill-Line Passes	5623.00
Prescriptions (Pill-line + KOP)	2746.00
Referrals/ER	164.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(7)(E)

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Accreditation - Review Complete

Last ACA Accreditation	2014-09-08
Last ACA Findings	100%
Last NCCHC Accreditation	2014-12-11
Last NCCHC Findings	Essential Standards Not in Compliance: J-A-05 Policies and Procedures J-A-07 Emergency Response Plan J-E-01 Information on Health Services J-E-12 Continuity and Coordination of Care During Incarceration J-G-01 Chronic Disease Services Deficiencies addressed and facility re-accredited.
Last PBNDS Accreditation	2016-04-12
Last PBNDS Findings	No medical findings-all medical care standards were met. Next PBNDS visit April 18, 2017.
Comments	One finding for the 2016 PBNDS visit was custody based. Deficiency: (b)(5) (b)(5)

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	18.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	18.00
Number of informal grievances.	0.00
Findings	None: Local policy is being followed, there is an appointemnt letter for the grievance officer,all grievances reviewed were noted to be in ecw.
Deliverables	NO DATA

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Risk Management - Review Complete

Trends	No identifiable trends noted.
Number of active RCAs/SOEs	0.00
Number of RCAs or SOEs completed during the last six (6) months.	1.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	N/A
Findings	(1) Sequence of events completed. Sent to OHA and no RCA was recommended. No need for a CAP as the medical response was adequate.
Deliverables	N/A

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	No - See findings below.
Are mouth checks being conducted with every administration?	No - See findings below.
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	1.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	During my observation it was noted that the pill line nurse was not using two forms of identification; when asked, she stated she knew these individuals. Out of approximately 35 passes, I saw 3 detainees who did not have a mouth check.
	(b)(5)
Deliverables	None

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	No - See findings below.
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	No - See findings below.
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	N/A - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	The facility was not conducting man-down drills for the night shift per IHSC policy . Recommended to perform one drills, per month per shift as IHSC policy indicates. Once notified, the site conducted a night man down drill during our visit.
Deliverables	None

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Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	No Findings: The SDS is located at nurses station, includes all chemicals in the facility. GEO maintains storage of the cleaning supplies.
Deliverables	None

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	3.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	3.00
Number of psychotropic consent forms among the identified consent forms.	6.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	6.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	Please follow up on dental forms on site. 5 detainees were identied to have dental procedures out of the 25. Only 3 out of the 5 completed consent forms. viewed 12 random charts for detainees who had dental procedures during the months of Dec, Jan and Feb. 10 had completed consent forms and 2 did not but they had refusal forms signed for the refused dental procedure. No recommedations needed.
Deliverables	none

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	23.00
Out of the transfers reviewed, how many had a positive chest X-ray?	3.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	2.00
Out of the transfers reviewed, how many have active TB?	0.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	2.00
Number of transfers with medication instructions clearly provided.	2.00
Number of transfers signed by a proper level provider.	25.00
Findings	25 transfer summaries were reviewed for audit of the following 3 agreed-upon TB-related questions: 4. Was TB clearance annotated correctly? 23 records -- YES; 2 -- records NO (including 3 records for TB patients) 5. If detainee had positive CXR, were lab results documented to verify non-infectiousness? 3 records - NO. For the 3 records corresponding to TB patients, the TB-CM report that must be printed and attached to transfer summaries were missing documentation of the 3rd sputa result. 6. If the transfer summary indicates that the detainee is not being treated for active TB, are anti-TB medications not listed? 23 records -- YES; 1 record -- N/A; 1 record -- NO (Transfer summary indicated "detainee not being treated for Active TB" should have indicated "yes", detainee on TB treatment). Recommendation - please be reminded to educate nursing staff to review relevant documentation to

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	ensure accuracy of information so the receiving facility will have correct and complete information.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	5.00
Number of prescreens that used a translator.	2.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	2.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	23.00
Number of prescreens with documentation completed in eCW prior to intake screening.	16.00
Findings	Based on charts reviewed, there appeared to be some inconsistency in the documentation of use of a translator, on the pre-screening, vs. use of a translator on the intake screening, For example, of the 25 pre-screenings reviewed, 8 had documentation consistent to the intake screening (i.e. both the pre-screening and the intake screening may have indicated no translator was used due to the detainee speaking fluent English. However, there appeared to be inconsistency with the rest of the charts. For example, the pre-screening may indicate that no translator was available during the pre-screen, but the intake screening would indicate use of a translator, and include the translator number. This reviewer is unclear as to whether there is a lack of a phone where the pre-screens are conducted, thus they could not call a translator. Alternatively, perhaps there is a drop-down menu for use of a translator during pre-screening, and they kept a default option.) Additionally, there were some charts were the pre-screen would indicate there was no translator available, but the intake screening would say the detainee speaks fluent English. Of the 25 pre-screens reviewed, only five indicated the detainee was triaged according to the pre-screen policy. Per the pre-screen policy, No Priority should be documented/indicated for detainees with no medical issues, and Priority Levels should be documented for others. Only five charts indicated No Priority or a Priority Level. Of the 25 pre-screens

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	reviewed, 16 of them were compleltely documented in eCW pior to the Intake screening. Nine were documented in eCW after the intake screening was documented.
Deliverables	NO DATA

Prescreening Observations - Review Complete

Number of prescreen encounters observed.	7.00
Number of prescreen encounters observed that allowed for patient privacy.	7.00
If privacy was not provided, where was the prescreen performed?	n/a
Number of prescreen encounters that used language services.	1.00
Number of prescreen encounters completed within two hours of arrival.	7.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	7.00
Number of prescreen encounters prioritized.	1.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	1.00
Findings	n/a
Deliverables	None

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	8.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	8.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	16.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	24.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	24.00
Of the intake screening records, how many were TB positive?	1.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	1.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	2.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	2.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	9.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	9.00
Number of intake screenings reviewed by an RN or above within 24 hours.	2.00
Findings	Of the 25 Intake Charts reviewed, three Intakes were conducted by a LVN, thus requiring review by a RN or higher. Of those three Intakes conducted by a LVN, two were reviewed by a RN within 24 hours. One did not indicate a review by a RN.
Deliverables	NO DATA

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Intake Screening Observations - Review Complete

Number of intake screenings observed.	2.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	1.00
Number of intake screening observations where a full set of vital signs were taken.	2.00
Number of intake screening observations that used language services.	0.00
Of the intake screening observations that used language services, how many were appropriately conducted?	0.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	0.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	2.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	During the intake, RN realized that they had not reviewed the prescreening form and stated that they normally do so. Both detainees spoke English so no language services were needed. RN stated they normally enter the data into eCW at time it is gathered, but reverted to gathering on paper due to clinic movement issues. Stated would enter as soon as they could.
Deliverables	None

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Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	25.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	23.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	23.00
Number of chronic care encounters with psychiatric medications.	10.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	10.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	10.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	0.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	18.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	25.00

Findings

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	Only findings found were (7) chronic care charts without a global alert. Recommend using chronic care templates for initial and follow-up visits when applicable.
Deliverables	None

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	6.00
Number of chronic care encounters observed that utilized language services.	5.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	6.00
Findings	none
Deliverables	none

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	25.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	25.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	25.00
Of the physical examinations with pain assessment, how many were addressed?	3.00
Number of physical examinations with clinically significant findings.	5.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	5.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	25.00
Number of physical examinations for females.	0.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	0.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	0.00
Findings	None
Deliverages	None

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	5.00
Number of physical examination encounters with a full set of vital signs taken.	5.00
Number of physical examination encounters observed that were completed within 14 days.	5.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	No Findings: Noted that CHAPERONES AVAILABLE UPON REQUEST signs are posted in waiting areas and exam rooms. Staff indicated that any examination, or injections requiring exposure of genatalia or below the waist would be chaparoned.
Deliverables	None

AMERICAN OVERSIGHT

Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	2.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	2.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	3.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	3.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	25.00
Number of sick call encounters where the reason is documented in the "Reason" field.	25.00
Number of sick call encounters where the reason for the visit was from an approved category.	25.00
Number of sick call encounters addressed by a nurse.	25.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	0.00
Findings	None
Deliverables	None

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	Yes
Findings	sick call starts at 0530. The facility conducts same day sick call. Evaluator observed 10 sick call encounters. The facility utilizes a multi-tier sick call system.one RN conducts the intial triage and determines if the patient needs to be seen bu a RN or MLP, another completes vitals, after the assessment, the patient waits to be seen by a RN or MLP randomly chose 15 sick call encounters and all encounters were annotaed on the sick call log.
Deliverables	None

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MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	16.00
Number of MHU 23 hour observation records with discharge encounters.	9.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	20.00
Number of MHU 23 hour observation records with telephone order admission.	7.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	6.00
Number of MHU 23 hour observation records labeled "Observation".	8.00
Findings	Only 20 cahrts found in this section. Four (4) encounter did not have a TE for the medication orders or admission orders (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Only 7 MHU admissions were required a TE-all other admissions were by providers so a TE was needed (The answer for the following question is not a negative finding:Number of MHU 23 hour observation records with telephone order admission as admissions were not required for all MHU admissions). (b)(5) (b)(5)
Deliverables	NO DATA

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MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	NO DATA
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	22.00
Number of MHU full admission records reviewed.	24.00
Number of MHU full admission records with admission encounters.	24.00
Number of MHU full admission records with discharge encounters.	22.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	24.00
Number of MHU full admission records with no PE within the past year.	0.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	24.00
Number of MHU full admission records with acuity level assigned.	24.00
Number of MHU full admission records with all medications placed on pill line.	24.00
Number of MHU full admission records with 24 hour chart reviews everyday.	24.00
Number of MHU full admission records for patients in segregation for medical overflow.	1.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	1.00
Number of MHU full admission records with a nursing care plan.	24.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	9.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	24.00

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Number of MHU full admission records with mental health diagnoses.	14.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	14.00
Number of MHU full admission records without mental health diagnoses.	10.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	10.00
Findings	Nursing staff is incosistently charting care plans as noted previously. After a second review of charts, it was noted that initial care plans are being done and scanned in eCW. However, when an additional NANDA diagnosis is added to the existing care plan (s), there is inconsistency in scanning the new CPs into eCW. Some nurses are using eCW based CPs to chart and some are using paper CPs. When paper CPs are used, nurses are referencing that the CP is being continued and are writing that the issue is resolved when the CP is not in use anymore. The lead HSA of this site visit was made aware of the findings and is in agreement with citing the lack of additional care plans scanned into eCW (specifically when a new diagnosis is added/identified by nursing staff) as a negative finding for the charts reviewed. This reviewer consulted the IHSC Chief Nurse, who recommended the use of paper CPs until approved eCW CPs are established.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	23.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	23.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	23.00
Number of suicide watch records where the need for finger foos was annotated.	23.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	23.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	23.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	23.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	18.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	23.00
Findings	This reviewer only found 23 charts. See excel spreadsheet for specifics on A#s
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	0.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	0.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	0.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	0.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	0.00
Findings	No Findings; There are currently no detainees on suicide watch. Reviewed recent records and did not find any descrepancies
Deliverables	None

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Hunger Strike - Review Complete

Number of hunger strike records reviewed.	1.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	1.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	1.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	1.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	1.00
Number of hunger strike records with special needs.	1.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	1.00
Findings	Only one chart found. (b)(5) (b)(5)
Deliverables	NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	21.00
Number of segregation records where daily segregation rounds by nursing are documented.	25.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	25.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	25.00
Number of segregation records where the patient was seen weekly by mental health.	24.00

Findings

(b)(5); (b)(6); (b)(7)(C)

Deliverables

NO DATA

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After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	10.00
Number of after hours medication records with the patient's identification number documented.	10.00
Number of after hours medication records with medication order(s) documented in eCW.	10.00
Number of after hours medication records that were generated by a nurse as a telephone order.	10.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	10.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	None
Deliverables	none

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	Yes
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	10 charts were reviewed, each chart was noted to have medication taken from the overnight cabinet by nursing staff and there was an order placed in ecw by the provider for the medication in each chart.
Deliverables	none

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Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	25.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	25.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	5.00
Reasons for why a translator was not used.	The provider documented that either the detainee spoke fluent English or that the provider was fluent in the detainee's language.
Findings	None
Deliverables	None

Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	NO DATA
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	NO DATA
Findings	No Findings. The "I Speak" posters were noted in all central locations. I was advised GEO has a certified sign language interpreter onsite. (b)(5)
Deliverables	NO DATA

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Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	Yes
Findings	Clia certification does not expire until 2018
Deliverables	none

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Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	14.00
Number of refridgerator temperature logs that are up to date.	14.00
Number of refridgerator temperature logs that are out of range.	1.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	1.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	No - See findings below.
Are cleaning logs present in the MHU and up to date?	Yes
Findings	The refrigerator in the lab was out of range twice last month, when it was found to be too cold. It was determined the freezer door was open and that lowered the refrigerator temp. IHSC policy requires AEDs, crash cart and the emergency bag be checked daily. A best practice would be that they be checked each shift.
Deliverables	None

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Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	12.00
Number of daily assignment sheets completed and archived .	12.00
Number of daily assignment sheets with one emergency team identified per shift.	12.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	12.00
Number of daily assignment sheets with clinic inspection completed and signed.	12.00
Are detainee referrals documented?	Yes
Findings	The daily report sheets were completely filled out; observed random 3 per month for the months of Dec, Jan, Feb and March
Deliverables	none

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	No Findings
Deliverables	None

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	None
Deliverables	none

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Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	6.00
Number of federal civil service employee personnel files reviewed.	1.00
Number of contractor personnel files reviewed.	10.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	No - See findings below.
Is all current malpractice insurance information for contractors up to date?	No - See findings below.
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	2.00
Of the personnel file records for priveleged staff, how many are current?	2.00
Number of personnel files with current and signed Health and Ability form.	16.00
Number of personnel files with a signed statement of confidentiality (one time).	17.00
Number of personnel files with a signed statement of risks and responsibility (one time).	0.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	17.00
Number of personnel files with a signed release of information form (one time).	0.00
Findings	Electronic Tracker being updated. Malpractice insurance being tracked by the Contracting Company
Deliverables	None

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Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	8.00
Number of federal civil service employee credentialing files reviewed.	1.00
Number of contractor credentialing files reviewed.	6.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	No - See findings below.
Number of credentialing files with health statements.	15.00
Number of credentialing files with current, valid, and unrestricted license.	15.00
Number of credentialing files with license primary source verification.	15.00
Number of credentialing files with documentation of primary education.	15.00
Number of credentialing files with education primary source verification.	15.00
Number of credentialing files reviewed for physicians or psychiatrists.	1.00
Number of physician or psychiatrist credentialing files with documentation of residency.	1.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	1.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	1.00
Number of credentialing files with a curriculum vitae or resume.	7.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	0.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	3.00
Number of credentialing files with scope of practice.	15.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	4.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	15.00
Number of peer reviews reviewed.	11.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	11.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	All credentialing folders need to be updated with the PHS officers COERs and CV's. Out of the 15 charts only 1 was missing the health statement and only 2 were missing confidentiality form. The AA is in the process of updating her tracker.
Deliverables	none

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	No - See findings below.
Is the "electronic tracker" up to date and complete?	No - See findings below.
Number of employee health files reviewed.	10.00
Number of employee health files with current TB (PPD or CXR) documentation.	9.00
Number of employee health files with current Hepatitis B vaccination or declination form.	9.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	6.00
Number of employee health files with current respirator medical clearance.	8.00
Number of employee health files with current respirator fit test.	10.00
Number of employee health files with emergency contacts.	0.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	Yes
Findings	Access includes the HSA designee which is the Administrative Assistant, who is in the process of updating the health records tracker. Emergency contact information is maintained in the personnel file.
Deliverables	None

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Training - Review Complete

Number of training folders reviewed.	15.00
Number of training folders with HSD-500.	15.00
Number of training folders with a signed position description.	14.00
Number of registered nurse training folders reviewed.	8.00
Number of registered nurse training folders with RN Physical Exam Training.	8.00
Number of training folders with continuing medical education credits.	0.00
Number of training folders with BLS for health care providers or CPR and AED certification.	15.00
Number of radiation safetoy officer training folders with radiation safety training.	0.00
Findings	no CMEs noted in the training files for YR 2016. The HSA stated that she was informed that only CMEs that are paid for by the Agency or CMEs that were obtained while using admin leave to complete them are the only CME's that are required to go in the training folder
Deliverables	none

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	Yes
Findings	No Findings: I verified documentation of the recent Varicella outbreak had been entered into sharepoint.
Deliverables	None

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	3.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	No - See findings below.
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	There was no signed approval for non traditional shifts but the HSA sent a approval request to the Regional during our visit and she is awaiting approval
Deliverables	none

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IHSC Health Systems Assessment

Facility Overview

Months: April, May, and June **Bed Capacity:** 1575 **MHU Beds:** 10

Daily Census: 1358 **Male:** 1192 **Female:** 166 **Juveniles:** 0 **LOS:** 111

Average Number of Encounters					
Category	**Month 1**	**Month 2**	**Month 3**	**Average**	**% pop**
Pre-screening	534	656	409	533	39.2
Intake	521	650	406	525	38.6
Physical Exams	621	541	433	531	39.1
Vitals/Labs	245	325	128	232	17.1
Sick call	856	955	827	879	64.7
Pros/Imm	164	170	161	165	12.1
Acute	480	571	726	592	43.5
Chronic	88	120	99	102	7.5
Mental Health	477	502	513	497	36.6
Dental	278	250	266	265	19.5
Emergent/Urgent	203	183	186	191	14.0
MHU	809	716	682	736	54.1
Seg	989	873	1026	963	70.1
Admin	177	187	151	172	12.7
Transfers	609	619	614	614	45.2
Totals	7429	7700	7131	7420	546
Pill-line passes	659	606	512	592	43.6
RX (Pill-line + KOP)	3250	3572	3164	3329	245
Referrals / ER	124	130	111	122	8.9

(b)(7)(E)

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PRE-ARRIVAL REVIEW

Accreditation

Most recent ACA, NCCHC, and PBNDS surveys. List type of survey and date.

Evaluation Method		
Survey	**Date**	**Findings / Recommendations**
ACA	Sept 25-26 2017	No findings 100% compliant
NCCHC	Jan 22-24 2018	No findings 100% compliant
PBNDS	Apr 17-19 2018	No findings 100% compliant
Comments	Fully successful accreditations with no findings and no corrective action plans indicated. Many accolades and best practices identified by auditors. Some of which are now in the 2016 PBNDS revisions.	

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Grievances

Evaluation Method:	Observation	
Items to Review *(review 100% during past year)*	**Yes, No, or N/A**	**Comments**
1. Have there been any medical grievances reported through QI/JIC/CRCL/DRIL *(if so, provide type in comment section)*	YES	1 grievance elevated to JIC.
2. Is there a local procedure (SOP) for managing grievances?	Yes	
3. Is there an identified grievance officer?	Yes	
4. Is the log book kept and up to date?	Yes	
5. Were all Grievances addressed in a timely manner?	Yes	
6. Number of Formal/Informal grievances: 9 / 2		

Findings/ Recommendations:	. We are a pilot site sponsored by ICE for an electronic grievance system. Currently operated by Talton using tablets.
Deliverables:	**N/A** Our experience with electronic grievances is it results in a higher than normal number of false grievances as the detainees use it as an email communication/request system.

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Incident Reports/RCA/SOE

Evaluation Method:			
Items to Review *(review 100% during past year)*		**Yes, No, or N/A**	**Comments**
1. Were there any trends noted from reported incident reports or RCAs for FY17?		No	CAP assigned by MQM and completed addressing psychiatric med refusals and consents.
2. Are there any active RCAs/SOE?		No	
3. Has a RCA or SOE been completed during this FY? If so, complete #4		N/A	
4. Was a CAP initiated and/or completed for the RCA or SOE?		N/A	
a. If CAP initiated, note status and due date.		NA	
Findings/ Recommendations:	Facility independently initiated a CAP following a pattern of medication errors related to pharmacy practices. Additionally initiated HFEMA to address higher than normal new admissions with active withdrawal symptoms.		
Deliverables:			

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ON-SITE OBSERVATIONS

During site observations, the reviewers should observe staff members carrying out the task, interview staff, review medical records and review supporting documents (i.e. logs, minutes, binders, electronic trackers, etc.).

Medication Administration (Observations-Onsite Review)

Question (10 ENCOUNTERS)	Improvement Plan (1,2, or 3)	Comments
Is pre-pouring occurring? **(Be sure to observe more than one nurse on multiple shifts) Level 2@100%**	N/A	No
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)? **Level 2 @100%**	N/A	Yes
Are mouth checks being conducted with every administration? Observe 10 patients (if possible) on multiple shifts **Level 1 @80%**	N/A	Yes
Are all entries in the MAR complete (allergies, staff initials, etc.)? Observe 10 different MAR; **Level 1 @80%**	N/A	Yes
Are nurses documenting the medication administration immediately after the medication is administered**? Level 2 @100%**	N/A	Yes
Number of all medication refusals documented on the MAR/eMAR **Denominator**	NA	10/10

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Of the identified medication refusals from the MAR, how many refusals did have an accompanying signed refusal form? **Level 2@90%** .	N	A	10/10 100%
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal in eCW **Level 1 @100%; See guide eon ECW notification**	N	A	0/10 all were notified.

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Emergency Preparedness and Response

Question	Improvement Plan (1,2, or 3)	Comments
Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)? Refer to guide: **level 1 @90%**	NA	Yes. All documentation for monthly man down present and reviewed with staff per policy.
Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)? Refer to guide **level 1 @90%**	NA	Yes. Each fire drill is recorded and reviewed with staff per policy.
Is there documentation showing completed date and time of mass casualty drills * (each shift should have a complete drill within a three year period)? *Table top/mock drills are acceptable replacements for drills not conducted facility wide Refer to guide: **level 1 @90%**	NA	Yes. All documentation for the annual mass casualty drill down present and reviewed with staff per policy.
Are clinic staff trained on emergency equipment (AED, first Aid kits, fire extinguisher, etc?) Yes/No **level 1 @90%**	NA	Yes. Annual training noted for all staff for equipment.
Do emergency scenarios vary? Yes/No?? **Level 100 % if No**	NA	Yes. Good mixture of scenarios to cover multi events.
Is the difference between a drill and an actual event evident in the write-up?): **Level 1 @100%**	NA	Yes. On top of write up a box clearly distinguishes between drill and real events.
Is there process in place to distribute "an after-action report to all staff? **Level 1 @90%:**	NA	Yes. After actions are read at shift report and left in binder to read for those not present.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event? **Level 1 @100%**	NA	Yes. AA updates call list monthly and recall tree is initiated quarterly to ensure accuracy.
Comments:	Comprehensive plan in place and followed for all above.	
Deliverables:	None	

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Consent Forms

	Section Completed Under the Pre-Audit Chart Reviews		
Question		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of consent forms (General consent) that were complete (not missing detainee signature, witness, or date). **Level 1 @100%:** Can escalate to Level 2 if not resolved by the completion of the assessment		NA	10/10 100% compliance. No forms missing and all sections filled out correctly.
2. Number of dental consent forms among the identified consent forms.		NA	10
3. Number of dental consent forms that were complete (missing detainee signature, witness, or date) **Level 1 @90%**		NA	10/10 100% compliance. No forms missing and all sections filled out correctly.
4. Number of psychotropic consent forms among the identified consent forms.		NA	10
5. Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date) **(Level 1 @90%)**		NA	10/10 100% compliance. No forms missing and all sections filled out correctly.
Findings/ Recommendations:	Transfer Summaries completed in the pre-audit Chart Reviews		
Deliverables:	None		

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Transfers

Reviewer

Evaluation Method:	**Section Completed Under the Pre-Audit Chart Reviews**	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of outgoing transfers authenticated appropriately (signed, stamped, and dated): **Level 1 @100%**	NA	25/25 100%
2. Number of outgoing transfers completed by LVN or above. **Level 1 @100%,**	NA	25/25 100%
3. Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility) Level 2 @90%	NA	25/25 100%
4. Of the 25 transfers reviewed for TB clearance documentation, how many correctly documented no TB treatment status? **see guide Level 2@90%**	NA	25/25 100%
5. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented no TB treatment status? see guide **Level 2@90%**	NA	All were documented correctly 25/25 100%
6. Of the 25 transfers reviewed for TB clearance documentation, how many - correctly documented TB treatment status? see guide: **Level 2@90%**	NA	25/25 100%
7. Of the 25 transfers reviewed for TB clearance documentation, how many - incorrectly documented TB treatment status? see guide: **Level 2@90%**	NA	All were documented correctly 25/25 100%

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Findings/ Recommendations:	no findings noted
Deliverables:	None

Pre-Screening

Reviewer:

Evaluation Method:	**Observe 10 pre-screens if Possible**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of prescreen encounters observed. **Denominator**	NA	10
2. Are language services being used during pre-screen if appropriate? **Level 2: if No**	NA	Yes
3. Number of prescreens with documentation completed in eCW prior to intake screening. **Denominator**	NA	10/10
4. Number of prescreen encounters prioritized. **Level 1: @90%**	NA	10/10
5. Number of Pre-screens encounters not prioritized appropriately: **Level 1 @90%**	NA	0/10 all completed correctly.
Findings/ Recommendations:	None	

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Intake Screening

Evaluation Method:	Observe 10 "Intakes" if Possible		
Items to Review *(review 25 records in the past month)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of intake screenings observed. (N/A) **Denominator**		NA	10
2. Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening. **Level 1 @90%**		NA	10/10
3. Number of intake screening observations where a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat were taken. **Level 2: @90%**		NA	10/10
4. Number of intake screening observations that used language services. **Level 2:@90%**		NA	8/8
5. Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)? **Level 1 @90%**		NA	10/10
6. Of the intake screening observations that used language services, how many were appropriately conducted? **Level 2:@90%**		NA	8/8
7. Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide. **Level 2:@90%**		NA	10/10

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8. Number of intake screening observations with security advice of special needs and housing disposition. **Level 1 @90%**	N/A	
Deliverables:	None	

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Chronic Care

Evaluation Method:	Observe 10 "Chronic Care Encounters"		
Questions		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of chronic care encounters observed that utilized language services appropriately. **Level 2 @90%**		NA	10/10
2. Number of chronic care encounters observed that were completed within the time frame indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit **Level 2 @90%**		NA	10/10
3. Number of chronic care encounters observed that were not completed within the timeframe indicated by a previous visit (greater than 90 days for unstable patients). **Level 2 @90%**		NA	all appointments completed within designated timeframe
Findings/ Recommendations:	no deficiencies noted		
Deliverables:	None		

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Physical Exams

Evaluation Method:	Observe 10 physical exams completed by different providers	
Items to Review *(review 25 records in the past month)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of physical examination encounters with a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken **Level 2@90%**	NA	10/10
2. Number of physical examination encounters observed that were completed within the specified timeframe. (Two Business days for PE-Cs, 7 days for –juveniles and, 14-days for adults) **Level 2@90%**	NA	10/10
3. Number of physical examination encounters observed that offered detainee provider referral when appropriate **Level 1 @90%**	NA	none observed needing referral.
Findings/ Recommendations:	no findings noted	
Deliverables:	None	

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Sick Call

Evaluation Method:	Observation		
Items to Review *(Observe 10 "Sick Call "Encounters if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Is sick call offered face-to-face on a daily basis?? **Level 1 if NO**		NA	yes
2. Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented) **Level 1; if NO**		NA	yes
3. Is translator services offered when appropriate during a sick call process? **Level 1; if NO**		NA	yes
4. Did RN utilize nursing protocols/guidelines during sick call encounters?		NA	10/10
5. Is a guardian present for any minor (<18 years of age) sick call? **Level 1; if NO and applicable**		NA	NA
6. Is there a sick call log used to document all encounters?		NA	yes Sick call log is kept electronically
Findings/ Recommendations:	1 note by RN stated they used nursing guidelines and correctly documented the treatment but did not specifically identify which guideline was utilized. (b)(5)		
Deliverables:	NM will provide retraining as indicated.		

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Medical Housing Unit 23 hr Observation

Evaluation		
Items to Review *(Observe 10 MHU 23-HR OBS if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU 23 hour observation records reviewed. **Denominator**	NA	10
2. Number of MHU 23 hour observation records with documentation regarding return to general population	NA	10
3. Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis documented on placement in the medical housing unit	NA	10
4. Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 2 business day. **Level 1: @80%**	NA	10
Findings/ Recommendations:	None	
Deliverables:	None	

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Medical Housing Unit full Admission Observation

Evaluation Method:	Observation	
Items to Review *(10 detainees if possible)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are all patients within sight or hearing of a qualified health professional? **Yes/No**??	NA	yes staff on duty at nursing station 24/7 within sight or hearing.
2. Number of nurses in the MHU at time of observation **(Denominator)**	NA	2
3. Number of patients in the MHU at time of observation	NA	8
4. Number of MHU full admission records with 24 hour chart reviews every day. (Review one 24-hour chart in detail to confirm review was done appropriately) **Level 1: @90%**	NA	8/8
5. Number of MHU full admission records with all medications (except KOP med exceptions see guide) placed on pill line. **Level 2 @90%**	NA	8/8
Findings/ Recommendations:	no findings noted.	
Deliverables:	None	

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Suicide Watch- Observations

Evaluation Method:	None observed on Site		
Items to Review *(Observe 10 detainees on "suicide watch" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of patients on suicide watch **Denominator**		NA	2
2. Number of patients on suicide watch with nursing assessment performed within the past 8 hours. **Level 3 @ 100%**		NA	2/2
3. Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule. **Level 3@ 100%.**		NA	2/2
4. Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours. **Level 3 @ 100%.**		NA	2/2
5. Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc). **Level 3@ 100%**		NA	2/2
Findings/ Recommendations:	no discrepancies noted		
Deliverables:	None		

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Hunger Strike-Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees on "Hunger Strike" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Was water available to detainees on hunger strike? **Level 3: if NO @90%**		NA	yes
2. Were meals (if observed during meal times) offered to patient and how MUCH OF THE of the food SERVED was eaten **Level 3: If NO @90%**		NA	yes
3. Of the hunger strike records with special needs, how many records indicate that the needs were addressed? **Level 3 @90%**		NA	6/6 = 100%
Findings/ Recommendations:	None		
Deliverables:	None		

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Segregation- Observations

Reviewer:

Evaluation Method:			
Items to Review *(Observe 10 detainees in "Segregation" if possible)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of MHU full admission records for patients in segregation for medical overflow. **(Denominator)**		NA	6
2. Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on every 8 hours according to MHU policy **Level 3 @90%**		NA	6/6
3. Was sick call offered to detainees in segregation or other specialty housing units? **Level 2 @90%**		NA	100%
Findings/ Recommendations:	no deficiencies noted		
Deliverables:	None		

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After-Hours Medication (night pharmacy)

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of after-hours medication log records reviewed. **(Denominator)**	NA	10
2. Number of after-hours medication LOG records that were generated by a nurse as a telephone order. **Level 2 @90%**	NA	3/3
3. Number of afterhours medication records that were generated by a nurse as a telephone order and were signed by a provider within 24 hours returning for next work shift **Level 2 @90%**	NA	3/3
4. Does the pharmacy have a reconciliation process?: **Level 2 if NO @90%**	NA	YES
5. Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed from the AHC: **Level 1 @100%**	NA	YES
6. Is all necessary information entered the fields of the After-Hours Cabinet (AHC) sign out log. **Level 1 @100%**	NA	YES
7. Is a medication log in place and reflective of quantities of medication	NA	YES

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stored in the night cabinet? **(Level 1 if NO)**	YES	
8. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed? **Level 2 @100%: if NO**	YES	
9. Is the after-hours verbal medication order entered eCW by the prescriber upon return to duty? **Level 2@100%**	YES	
10. Is the after-hours medication administration properly documented on the MAR or in the electronic health record? **Level 2@100%**	YES	
11. Is the night cabinet, clean, stocked, and organized?	YES	
12. Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications? **Level 2 @100%**	YES	
Findings/ Recommendations	None	
Deliverables:	None	

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Language Access- Observations

Reviewer:

Evaluation Method:	**Observation**	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	NA	Yes
2. Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities? **If No; level 2; @100%**	NA	Yes
Findings/ Recommendations:	The facility has access to TDD/TTY communication devices. In the past they have brought in Sign Language interpreters to the dorms, court, asylum, and medical appointments.	
Deliverables:	None	

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Diagnostic Services

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are laboratory services provided in adherence with CLIA Waived testing? **Level 3: @90%**	NA	Yes
2. Is there a current certificate for CLIA-waived testing? **Level 2@100%: CLIA services stopped until obtained.**	NA	Yes posted on wall of lab.
3. Are radiation signs posted on all doors leading to areas with radiation producing equipment? **Level 1 @100%, "SPOT-FIX, may escalate to Tier 2 If multiple rooms noted not addressed by the end of the visit**	NA	Yes posted on only door leading into x-ray room.
4. Are Dosimetry reports reviewed quarterly (MONTHLY FOR DECLARED PREGNACIES) by the Compliance officer or HSA? (Yes/No): **If No level 2@100%**	NA	yes
5. Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment? **Level 2@100%**	NA	yes

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6. Are staff dosimeter badges and controls stored in a central location and not near a radioactive source? **Level 2@ 100%**		Yes
Findings/ Recommendations:	No findings noted.	
Deliverables:	None	

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Log Books

Reviewer:

Evaluation Method:	Observation	
Items to Review	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of pharmacy refrigerator temperature logs reviewed **(Denominator)**	NA	Pharmacy has 4 refrigerators and 3 months were reviewed totaling 360 entries.
2. Number of pharmacy refrigerator temperature logs that have entries per shift for the past three months. **Level 1 @90%**	NA	7/360 were missing on the log
3. Number of refrigerator temperature logs that are out of range. **(Denominator)**	NA	7
4. Of the refrigerator temperature logs that are out of range, how many logs have documentation of action taken and follow-up ?(**Level 1 @90%)**	NA	6 entries had documentation 1 entry was missing
Are the sharps secured and count accurate? **Level 2 @100%, if NO**	NA	yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes ?(**Level 1 @90%)**	NA	Yes all sharps signed out as well as all sharps wasted are signed by 2 nurses.
Are the narcotics secured, (double locked) and counts within the last 3 months accurate (clinic and pharmacy supply)? **Level 3 @90%**	NA	yes
In review of 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts? **Level 1 @90%**	NA	yes

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Are the urgent care cart/trauma bag and AEDS checked daily for content (signatures, AED functionality, and expiration for the past 3 months? **Level 2 @90%**		Yes
Findings/ Recommendations:	None	

Daily Assignment Sheet (DAS)

Evaluation Method:	Observation	
Items to Review *(review 10 random days)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Number of daily assignment sheets reviewed per month) **Denominator**	NA	10
2. Number of daily assignment sheets that were archived appropriately.	NA	*No IP level; Observation only for 2018 audits*
3. Number of daily assignment sheets reviewed had at least one emergency team identified per shift. **Level 1 @90%**	NA	28/30
Findings/ Recommendations:	None Will reinforce to staff to write down emergency responders on DAS	
Deliverables:	None	

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Shift Report and Time-cards

Reviewer:

Evaluation Method:	Observation		
Items to Review *(audit 10 random cards)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are shift reports conducted?		*Yes*	*No IP level: best practice*
2. Is there at least one representative from each department?		*Yes*	*No IP level: best practice*
3. Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?		*Yes*	*No IP level Observation only for 2018 audits*
Findings/ Recommendations:	Structured system in place to efficiently process the time cards for verification and submission. Great teaming by AA, NM, and AHSA's.		
Deliverables:	Will be transitioning to Contract Coordinator versus AA by the next pay period.		

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Meetings

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings)*		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the two previous staff meetings, how many were conducted monthly and properly documented? **Level 1 @80%**		NA	100%
2. Out of the two previous public health, safety, and preparedness meetings, how many were properly documented? (**Level 1 @80%)**		NA	100%
3. Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented? **(Level 1 @80%)**		NA	100%
4. Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented. **Level 1 @80%**		NA	100%
Findings/ Recommendations:	**None**		
Deliverables:	None		

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PERSONNEL

Personnel and Credentialing Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files each if available*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the 12 personnel and credentialing files reviewed how many were PHS officers **No IP level**	NA	5
2. Of the 12 personnel and credentialing files reviewed how many were federal civil service employee **No IP level**	NA	1
3. Of the 12 personnel and credentialing files reviewed how many were contractors	NA	6
4. Does the facility have a process for tracking requirements electronically?: **No IP level**	NA	Yes
5. Of the 12 personnel and credentialing files reviewed how many records are for privileged staff (physician, psychiatrist, psychologist, dentist, and social worker)?: **No IP level**	NA	2
6. Of the 12 Privileged staff that are Licensed Independent Practitioners (LIPs) how many had current personnel files records current? (Yes/No) **Level 2@100%**	NA	2 (Yes) 100%
7. Of the 12 personnel files reviewed, how many contained a current and signed Health and Ability form? **Level 1 @90%**	NA	12/12
8. Of the 12 personnel files reviewed, how many contained a signed statement of confidentiality (one –time statement signed by	NA	12/12

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staff) **Level 1; @90%**		
9. Of the 12 personnel files reviewed, how many contained a signed statement of risks and responsibility (one time)?	NA	12/12
10. Of the 12 personnel files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time). **Level 1; @90%**	NA	12/12
11. Of the 12 personnel files reviewed how many contained a signed release of information form (one time). **Level 1; @90%**	NA	12/12
13.Of the 12 credentialing files reviewed, how many contained current, valid, and unrestricted license **Level 3: if not 100%**	NA	12/12
14. Of the 12 credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification **Level 1 @90%**	NA	12/12
15. Of the 12 credentialing files reviewed how many were reviewed for physicians or psychiatrists.	NA	1
16. Of the 12 credentialing files reviewed for physician or psychiatrist how many had documentation of residency. **Level 2@90%**	NA	1/1
17. Of the 12 credentialing files reviewed how many board certified physician or psychiatrist had documentation of board certification. **Level 2 @90%**	NA	2/2
18. Of the 12 credentialing files reviewed how many had a copy of a curriculum vitae or a resume. **Level 1 @90%**	NA	12
15. Of the 12 credentialing files reviewed how	NA	see below

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many PHS officers had at least two years of evaluations (COERS). **Level 1 @90%**	NA	5/5 3 had 2 year COERS, and 2 were new CAD.
19. Of the 12 credentialing files reviewed how many had current National Provider Data Bank information. (renewable every 2 years) **No IP level**	NA	2/2
20. Of the 12 credentialing files reviewed how many had scope of practice documentation (Pertinent staff only) **Level 1 @90%**	Level 1+ 91.5%	11/12 Missing 1 scope of practice for LVN.
21. Of the 12 credentialing files reviewed for LIPs how many had a competency assessment or peer review. **Level 2 @90%**	NA	2/2 100%
22. Of the 12 personnel files reviewed, how many contained training folders with HSD-500 record. **No IP level**	NA	12/12
23. Of the 12 personnel files reviewed, how many contained training folders with a signed position description. **No IP level**	NA	*No IP level Observation only for 2018 audits* 12/12
24. Of the 12 personnel files reviewed, how many contained registered nurse training folders reviewed. **No IP level**	NA	*No IP level Observation only for 2018 audits*
25. Of the RN personnel files reviewed, how many contained registered nurse training folders with RN Physical Exam Training. **No IP level**	NA	5/5
26. Of the 12 personnel files reviewed, how many contained continuing medical education credits. **No IP level**	NA	7/12
27. Of the 12 personnel files reviewed, how many contained BLS for health care providers or CPR and AED certification. **Level 1 @90%**	NA	12/12

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Employee Health Files

Reviewer:

Evaluation Method:	Observation	
Items to Review *(Review 12 files)*	**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Are employee health files kept separate from other files? (Yes/No) **No IP level**	NA	Yes
2. Is access to employee records limited to the compliance officer, HSA, and AHSA(s) and AA? **No IP level**	NA	Yes
3. Of the twelve employee health reviewed how many files had past year's TB (PPD or CXR) documentation. **No IP level**	NA	12/12
4. Of the twelve-employee health reviewed how many files had Hepatitis B vaccination or declination form. **No IP level**	NA	*No IP level Observation only for 2018 audits* 12/12
5. Of the twelve-employee health reviewed how many files had yearly Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing). **Level 1 @80%**	NA	Yes all records have Ishihara testing done at initial hiring. Policy does not require yearly testing.
6. Of the twelve employee health reviewed how many files had yearly respirator medical clearance. **Level 1 @80%**	NA	12/12
7. Of the twelve employee health reviewed how many files had yearly respirator fit test. **Level 1 @80%**	NA	12/12
8. Of the twelve employee health reviewed how many files had with emergency contacts.	NA	12/12
9. Are staff injuries and illnesses documented on the Workforce Injury Tool? **Level 2 @90%**	N/A	None

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Findings/ Recommendations:	None
Deliverables:	None

Training

Reviewer:

Evaluation Method:	Observation		
Items to Review *(Review 12 Files)* ***No IP level***		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Of the twelve training folders reviewed how many had documentation of completed Mandatory ICE Trainings (see guide for list of trainings)		N/A	100% Compliance : Using IHSC Training record documentation per policy
2. Of the twelve training folders reviewed how many had documentation of completed IHSC Mandatory Trainings(see guide for list of trainings)		N/A	100% Compliance : Using IHSC Training record documentation per policy
3. Of the twelve training folders reviewed how many had documentation of Completed Emergency preparedness Trainings(see guide for list of trainings)		N/A	100% Compliance : Using IHSC Training record documentation per policy
4. Of the twelve training folders reviewed how many had documentation of completed Occupational Health Trainings (see guide for list of trainings)		N/A	100% Compliance : Using IHSC Training record documentation per policy

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5. Of the twelve training folders reviewed how many had documentation of completed TB Management Trainings	N/A	100% Compliance : Using IHSC Training record documentation per polic
6. Of the twelve training folders reviewed how many had documentation of completed Mental Health Training for Behavioral Health Providers (see guide for list of trainings)	N/A	100% Compliance : Using IHSC Training record documentation per polic
Findings/ Recommendations:	100% Compliance : Using IHSC Training record documentation per policy	
Deliverables:	None	

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Schedules

Reviewer:

Evaluation Method:	Observation Reviewed June, July, August 2018 Schedules		
Items to Review *(Review 3 months Schedules)* *****No IP levels*****		**Improvement Plan Levels (1,2, or 3)**	**Comments**
1. Out of the three month schedules reviewed, how many had a legend to explain codes.		N/A	NWDC Tacoma utilizes current IHSC schedule template per policy. There are two legends; one for Nursing and one for Ancillary staff
2. Out of the three month schedules reviewed, how many had staff assigned 40 HRS PER WEEK20" per scheduling period.(Refer to guide)		N/A	All full time staff were scheduled for 40 hours per week
3. Out of the three month schedules reviewed, how many had provider coverage on weekend/holidays.		N/A	All weekends had both Provider and Behavioral health coverage
4. Out of the three month schedules reviewed, how many had actual work hours reflected for non-traditional shifts.		N/A	Refelected in the legend
5. Out of the three month schedules reviewed, how many had signed approvals for non-traditional shifts?		N/A	Current RHSA signed approval for non-traditional shifts
6. Out of the three month schedules reviewed, how many had a PDF copy each time a change was made to the schedule?		1	The PDF of changes is inconsistent. The AA will PDF the changes working from current backwards to catch it up and maintain going forward.
Findings/ Recommendations:	The PDF of changes is inconsistent. The AA will PDF the changes working from current backwards to catch it up and maintain going forward.		
Deliverables:	The AA will PDF the changes working from current backwards to catch it up and maintain going forward.		

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Summary

Topic	Recommendation
Sick Call	1 note by RN stated they used nursing guidelines and correctly documented the treatment bu
Daily Assignment Sheet (DAS)	Reinforce to staff to write down emergency responders on DAS (Education during Shift report
Personnel and Credentialing Files	Update training files with an up-to-date continuing medical education credits (CME) and reviev
Schedules	The PDF of changes is inconsistent. The AA will PDF the changes working from current backv
Time Cards	Structured system in place to efficiently process the time cards for verification and submission
Incident Reports	Facility independently initiated a CAP following a pattern of medication errors related to pharm
Grievances	We are a pilot site sponsored by ICE for an electronic grievance system. Currently operated b
Accreditations	Fully successful accreditations with no findings and no corrective action plans indicated. Many
Staffing	Losing PHS RNs and APPs faster than we can recruit. PHS CAD's can take a year and then s

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Recommendations from Facility

This structured form was sent out to the field in a non-finished format (per email from PM to CO at facility). There were many
The Improvement Plan level designations was inconsistent and very confusing and even after consultation and participating
The document sent to use as a go-by reference is different than the document we have been given to complete. This led to
(b)(5)
Our Compliance Officer has sent multiple messages regarding the issues as they were encountered to help facilitate improv

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Additional Comments *(include Section and item number)*

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Deliverables

Topic	Items	Due	Lead

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Unit Chiefs and Leadership Review Comment & Feedback

Leadership	Recommendations/ Comments/ Feedback
Chief of Health Operations	
Chief Advance Practice Practitioner	
Chief of PHSP	
Chief of Nursing Services Unit	
Chief of Medical Quality Management	
DAD-Administration	
DAD-Health Systems Support	
DAD Healthcare Compliance	
DAD Clinical Services Review	
Chief Medical Officer Review	
Chief of Staff Review	
AD, IHSC Review	

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Chief of Health Operations _____

Signature

Chief Advance Practice Practitioner _____

Signature

Chief of Public Health Safety and Preparedness Unit _____

Signature

Chief of Nursing Services Unit _____

Signature

Chief Medical Quality Management Unit _____

Signature

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Leadership Signatures

DAD Health Systems Support

_____

Signature

DAD Healthcare Compliance

_____

Signature

DAD Administration

_____

Signature

DAD Clinical Services Review

_____

Signature

Chief Medical Officer Review

_____

Signature

Chief of Staff Review

_____

Signature

AD, IHSC Review Status

_____

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined

Assessment Information - Report Complete

Facility	Tacoma
Site visit start date	2019-07-07
Site visit end date	2019-07-12
Fiscal Year	FY2019
Fiscal Quarter	Q4
Post-audit corrective action identified	Yes
Immediate corrective action identified	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Health Operations Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Complete
DAD, Clinical Services Review Status	Review Complete
DAD, Health Care Compliance Review Status	Pending Report Completion
DAD, Health Systems Support Review Status	Pending Report Completion
Chief of Staff Review Status	Review Complete
AD, IHSC Review Status	Pending Report Completion

Facility Information - Review Complete

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Facility HSA	(b)(7)(E)
Regional HSA	
Bed Capacity	1500
MHU Beds	9
Daily Adult Male Population	1136
Daily Adult Female Population	334
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	105
Facility Information Comments	Number of pill passes per day appear to be too high. That would equate to 488 per day. Referalls average 1 per month. Think this number is only reflective of ER send outs and not off-site appointments. Will ask HSA to validate this data.

Average Number of Encounters (Past 3 Months)

Prescreenings	602
Intake Screenings	582
Physical Examinations	599
Vitals/Labs	303
Sick Call	712
Pros/Imm	119
Acute	330
Chronic	498
Mental Health	118
Dental	246
Emergent/Urgent	206
MHU	727
Segregation	660
Admin	167
Transfers	598
Pill-Line Passes	14666
Prescriptions (Pill-line + KOP)	3207
Referrals/ER	1

Accreditation - Review Complete

Last ACA Accreditation	2017-09-05T04:00:00Z
Last ACA Findings	No data reported

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(b)(7)(E)

Last NCCHC Accreditation	2018-01-22T05:00:00Z
Last NCCHC Findings	No data reported
Last PBNDS Accreditation	2019-05-19T04:00:00Z
Last PBNDS Findings	No data reported
Accreditation Comments	No data reported

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	10
Of the after hours med log records reviewed, how many records documented the patient's identification number?	10
Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	0
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	No data reported
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	No
After Hours Medication Chart Review Findings	Best Practices- 1. Zip ties to secure individual med boxes provides a visual cue on which meds need to reconsiled each day; efficiency noted. 2. Color coded expirations labels on outside of each box; enhanced efficiency of monthy review. Findings 1. After Hours Medication Log is in place. Log entries do not include the patients name or time medication was removed. Numerous errors in logging; subtraction errors, failure to log medications out, "corrections to inventory" indicated poor accountability of prescribed medications. Documentation of errors does not conform with expected practice, correction in variety of colored pens, consist of "scribbled out" entries, individuals documenting over others entries. Pharmacy reports techs check inventory daily and expirations monthly, but management of medication variances have not consistently resulted in identifying where the meds went and have not been tracked on the IR tool. Unable to verify that the daily audit is performed as no documentation exists to document these quality checks. Unable to readily identify if the medications were taken based on T/O, V/O or by provider. 2. After hours cabinet is located in the lab where biohazardous material is spun and stored. 3. Checked 10 medication boxes; counts accurate. One medication label indicated the wrong count and this error was not identified for several months on the log before a correction to the count was made. No incident report for this issue. 4. OTC cabinet has labels that cover the manufacturer's directions.
After Hours Medication Chart Review Deliverables	(b)(5)

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(b)(5)

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	No
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	No
After Hours Medication Encounters Findings	1. The after hours medication cabinet is checked daily by the pharmacy techs, but the method of securing the boxes does not allow one to check for deteriorated medications. There is no log to ensure that the cabinet is checked for recalled items.
After Hours Medication Encounters Deliverables	(b)(5)

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	24
	25

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Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	21
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	21
Of the chronic care records reviewed, how many detainees had psychiatric medications?	16
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	16
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	24
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	24
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	24
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	1
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	1
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	21
Chronic Care Records Findings	Findings: 4 charts missing global alerts.
Chronic Care Records Deliverables	No deliverables needed/recommended. Discussed chart review findings with facility leadership during onsite visit.

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	4
Of chronic care encounters observed, how many were considered stable patients?	4
Of the stable patients observed, how many were completed within the appropriate timeframe?	4
Of chronic care encounters observed, how many were considered unstable patients?	0
Of the unstable patients observed, how many were completed within the appropriate timeframe?	0
Of the chronic care encounters observed, how many had a treatment plan?	4

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Chronic Care Encounters Findings	1) Best practice noted: • Provider/triage nurse completed peak flow as indicated by the chronic condition, • Provider reviewed lab results, disease control status and treatment plan with the detainee. • Provider reviewed the chronic medication refill process with detainee. • One of the chronic care encounters observed revealed that the APP had been consulting with CD and Pharmacy for chronic care management as needed. • Besides requesting chronic medication refill via the sick call process, the facility has a "pharmacy refill request form" process in place. The forms are located in the dorms and detainees can submit the form in a drop box near the Pill Line window marked "Medication Refill Request." Pharmacy checks this box M-F. At a glance it appears to be working efficiently. 2) Detainee refused a scheduled Chronic follow up appointment and no face to face refusal was obtained as the detainee refused to come to the clinic. Facility has a “Detainee Refusing Medical Services and/or Medication form” that custody has the detainee sign if he/she refuses to come to the clinic process in place. The form is then attached to IHSC refusal form and scanned into the detainee’s chart.
Chronic Care Encounters Deliverables	(b)(5)

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	8
Of the general consent forms reviewed, how many were complete?	8
Of the consent forms reviewed, how many were dental consent forms?	8
Of the dental consent forms reviewed, how many were complete?	8
Of the consent forms reviewed, how many were psychotropic consent forms?	9
Of the psychotropic consent forms reviewed, how many were complete?	9
Consent Forms Findings	A total of 25 consent forms were reviewed. There were 8 general consents, 8 dental consents, and 9 for psychotopic medication consents. 100% of the consents were not missing any required data.
Consent Forms Deliverables	No deliverables needed/recommended. Discussed chart review findings with facility leadership during onsite visit.

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Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	30
Of the daily assignment sheets reviewed, how many were archived appropriately?	0
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	18
Daily Assignment Sheets Findings	•30 daily assignment sheets were reviewed to include those with minor revisions. •Facility is utilizing the current IHSC Daily Assignment form, however the last two pages of the document are not being used. •The sheets are updated on every shift; however, several were not filled out completely as intended; Areas identified as incomplete includes: emergency teams for a given shift (12/30) and the dates (April more so than May and June). •Daily assignments sheets were being disorderly archived in a filing cabinet in MRT pending scanning. Site is behind on scanning the documents; last daily assignment sheet that has been scanned were June/July 2018.
Daily Assignment Sheets Deliverables	(b)(5)

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes

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Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	1. Did not observe x-ray technician; wear of badge unobserved. 2. PII (stack of x-ray logs) left in unlocked office.
Diagn/ stic Services Deliverables	(b)(5)

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	Yes
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	1) Last Mass casualty drill 12/5/18; Medical Emergency Equipment training: 3/11/19; 2) Facility has a self-study binder as well as ensuring PALMS training are completed 3) Scenarios vary (i.e. seizure, choking, unresponsive, hanging/suicide, chest pain, SOB, fire) 4) Staff are afforded the opportunity to review the after-action reports as they are kept in a binder in the multipurpose room for their review/signing of the roster. 5) Positive feedback/strengths/observations are being documented in the after-action reports such as "rapid response time, patient safety was ensured, clear delegation of roles, great teamwork/cohesive unit response, good communication, Recognized Geo ensured patient safety and worked well with team etc." Very few deficiencies or opportunities for improvement were noted in the after-action reports. 6) Copy of the Emergency call back roster is kept at Nursing station BEST PRACTICE NOTED: A "Medical Responder", "START Triage," and "Use of Force Debriefing (script)" cards are passed along during shift change ensuring the emergency

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	response team members acknowledges this responsibility during his/her shift.
Emergency Preparedness and Response Deliverables	NONE

Environmental Health Observation - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	Yes
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	All areas within compliance.
Environmental Health Deliverables	None.

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	0
Is there a local SOP for managing grievances?	No
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	11
Number of informal grievances.	0
Grievances Findings	Eleven formal medical grievances were file in the past three months and all were addressed within 5 business days as required by policy. Unable to identify any medical grievances reported through QI/JIC/CRCL/DRIL (this was verified with the Grievance Officer). The facility does not have a local SOP for managing grievances but follows the IHSC Detainee Medical Grievance System guidance. The Grievance binder/log is well maintained.
Grievances Deliverables	NONE

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Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	1
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	1
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	1
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	1
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	1
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	1
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	0
Hunger Strike Records Findings	Only located 1 Hunger Strike record from 3500 entries. On special needs specify commissary restriction not just confiscation of food.
Hunger Strike Records Deliverables	(b)(5)

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	0
Of the patients on a hunger strike, how many were offered meals?	0

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Of the patients on a hunger strike who were offered food, how much food was offered?	N/A
Of the food offered, how much of the food was eaten?	N/A
Of the patients on a hunger strike, how many had special needs?	0
Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	0
Hunger Strike Encounters Findings	N/A
Hunger Strike Encounters Deliverables	None

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	• Are hand washing equipment and hand sanitizers available in the clinic? o Yes, each provider room, Lab, and Urgent care rooms have sinks with soap. Hand sanitizer dispensers are located throughout the clinic, with one in the nursing station, teleradiology and before entering the breakroom. • Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint? o Yes, the active cohort of Mumps is posted on the Cohort tracking tool and the Mumps tracking tool • Is hand hygiene monitoring conducted and documented on the quarterly review? o Yes, 3Q, 5/14/19 and 2Q, 2/5/19 were completed with no negative findings. o Q3 was completed but not yet filed within the PHSP binder; it is now placed in the binder.
Infectious Disease Prevention Deliverables	none

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	11
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	11
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	0

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Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	3
Of the records with a pain scale greater than 0, how many were assessed?	3
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	11
Of the intake records with clinically significant findings, how many were referred appropriately?	11
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	1
Intake Screen Records Findings	Translator use was appropriate. If not used, it was due to provider fluent or English speaking detainee, 0 documented above.
Intake Screen Records Deliverables	(b)(5)

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	8
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	8
Of the intake screen encounters observed, how many included a full set of vital signs?	8
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	8
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	8
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	8
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	8
Intake Screen Encounters Findings	Findings- Three staff observed. Two of the nurses asked 100% of the questions as intended. One nurse, on one intake, generalized

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	some questions instead of asking them individualy. This same nurse asked 100% of the questions on subsequent observations. The surveyor moved from room to room to maximize opportunity to see multiple intakes. Clinic processes very efficient. Intakes thorough with relevant additional questioning when patient responded affirmative to questions asked. Time and care taken to get a full assessment of patient's needs and referrals to the appropriate level of provider initiated.
Intake Screen Encounters Deliverables	None.

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	13
Of the language access records reviewed, how many did not use a translator?	12
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	12
Language Access Records Findings	Out of the 25 intake records reviewed for language access purposes, 13 documented that a translator was utilized. For the 12 where a translator was not utilized, all 12 documented the reason why a translator was not utilized. All 25 records reviewed were in compliance for language access purposes.
Language Access Records Deliverables	No data reported

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	Staff able to verbalize the process for TYY/TDD access to services.
Language Access Encounter Deliverables	None

Log Books - Review Complete

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How many pharmacy refrigerator temperature logs were reviewed?	3
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	3
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	No
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	Yes
Log Books Findings	1. Sharps are bagged in packs. When counting, the count is being performed by bag. Recommend using breakaway tape and date and initials on bag of individual performing the the bag preparation. Nurse can count by 10s if bags are properly sealed, dated and initials. 2. Narcotic and sharps logs contain errors that have been scribbled over and counts are not always documented correctly on first try. 3. Pharmacy controlled substance cabinet has an exceess amount of crushed medication returned from nursing. It appears that controlled substances are being prepared in advance of confirming that the patient wants them which would indicate pre-pouring is occurring. 4. Excess number of controlled substances are stored in the pill-cart.
Log Books Deliverables	(b)(5)

Medication Administration Observation - Review Complete

Is prepouring occurring?	Yes
How many medication administrations were observed?	13
	13

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Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	
Of the medication administrations observed, how many mouth checks were conducted?	7
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	13
How many MAR entries were observed?	13
Of the MAR entries observed, how many were complete?	13
Of the MAR entries observed, how many medication refusals were documented?	10
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	6
Of the identified medication refusals, how many were high-risk medications?	10
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	10
Medication Administration Findings	Findings: 1. Patient IID only contained the nurse scanning the ID 2. Mouth checks did not meet expected threshold. 3. Pre-pouring was occuring for segregation patients and insulin patients. 4. Non-compliance with the refusal process. Refusal forms not being utilized, no consistent face-to-face encounter related to the refusal or seeking information with regards to the reason of the refusal. Alternate form used.
Medication Administration Deliverables	(b)(5)

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
	2

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Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	2
Meetings Findings	Positive findings - 1. Staff meetings were in a very nice format. Staff attendance rosters with exceptional compliance in having all signatures in a timely fashion. 2. Health and Safety meeting would benefit from being more robust; consider using a SWOT format when reporting on man down drills and fire drills to include plans for corrective actions and any follow-up to include effectiveness of CAPs documented.
Meetings Deliverables	None

MHU Full Admission Chart Review - No data reported

How many MHU full admission records were reviewed?	No data reported
Of the MHU full admission records reviewed, how many had admission encounters?	No data reported
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	No data reported
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	No data reported
Of the MHU full admission records reviewed, how many had a nursing care plan?	No data reported
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	No data reported
Of the MHU full admission records reviewed, how many had patient education provided daily?	No data reported
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	No data reported
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	No data reported
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	No data reported
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	No data reported
MHU Full Admission Records Findings	No data reported

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MHU Full Admission Records Deliverables	No data reported

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	4
How many patients are in the MHU full admission at the time of observation?	4
How many MHU full admission patients have a 24-hour chart review everyday?	4
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported
How many MHU full admission patients have medications?	4
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	4
MHU Full Admission Encounters Findings	1) A detainee in MHU without MHU Admission encounter/orders; the 24-hour chart check and daily MHU Provider round after being placed in the MHU were the opportunities to have identified this oversight.
MHU Full Admission Encounters Deliverables	(b)(5)

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	12
Of personnel and credentialing files reviewed, how many were PHS officers?	3
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	3
Of personnel and credentialing files reviewed, how many were federal civil service employees?	1
Of personnel and credentialing files reviewed, how many were contractors?	9
Of personnel and credentialing files reviewed, how many records are for privileged staff?	4

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Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	4
Of the LIP staff records reviewed, how many had personnel files records current?	4
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	3
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	12
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	12
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	12
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	12
Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	12
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	12
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	12
Of the staff records reviewed, how many had scope of practice documentation if applicable?	12
Personnel and Credentialing Files Findings	One peer review was in progress and awaiting reciept from HQs. AA was actively engaged in repeated follow-up since its expiration. racker was up to date and had areas that were pending updates highlighted. Very good system in place that is effectively managing all personnel, training, and health records requirements.
Personnel and Credentialing Files Deliverables	None.

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Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	18
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	18
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	16
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	25
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	9
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	14
Of the physical exam charts reviewed, how many were for adult females?	1
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	1
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	1
Physical Exam Records Findings	facility received a pass rating (maintained the threshold) for all criteria above.
Physical Exam Records Deliverables	No deliverables needed/recommended based on the chronic care chart review findings. Discussed chart review findings with facility leadership during onsite visit.

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	8
Of the physical exam encounters observed, how many included a full set of vital signs?	8
Of the physical exam encounters observed, how many were completed within the specified timeframe?	8

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Of the physical exam encounters observed, how many included a detainee request for a chaperone?	0
Of the physical exam encounters observed, how many had an abnormal vital sign?	0
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	0
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	8
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	8
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	0
Physical Exam Encounters Findings	• 8 PEs were observed (3 PE-C were completed by TDY providers, 2 PE-S were completed by RN staff and 3 PE-C were completed by Facility Providers) • Facility is working ahead on PE-S; as time permits, the weekend and evening staff have been working proactively to accomplish this task. • An annual PE refused to come to clinic; Face to face refusal form was not obtained • Best practice Observed: o All questions were asked as outlined in the PE templates; (even when the provider was conducting the evaluation in the MHU, she utilized a printed copy of the PE template/questions) o HPI/Peak flow completed/documented as appropriate o Provider inquired about receipt of patient education brochure at intake; provided information regarding dental/mental health services and treatment plan o “A chaperone will be provided upon request” sign was posted in exam rooms (in English and Spanish) o Translation services provided during PE-C in the MHU room (portable phone)
Physical Exam Encounters Deliverables	IHSC Refusal of treatment policy/process was reviewed with the RHSA. Deliverable for meeting intent of refusal process addressed in another section of this assessment.

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	8
Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	Yes
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	8
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	0
Prescreen Encounters Findings	Prescreening performed by memory and one question not asked for any of the 8 new entrants. The question regarding being suicidal

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	was done in a manner that was leading for a negative response. Nurse did not look comfortable askingthis question. No other findings noted.
Prescreen Encounters Deliverables	1. Spot check 5 nurses performing prescreen and intake to ensure all questions are being asked consistently. Report findings to RHSA by 10/01/2019.

Risk Management - Review Complete

Trends	1) 2018 Top 6 Event Types via the IR system: Injury (144), Fall (22) Altercation (physical) (19), Medical Emergency (14), Use of Force (14), Medication Error (Med. Administration) (12); Facility has been locally tracking/addressing Medication related incidents 2) Downward trend in IR reporting volume is noted (2016: 387; 2017: 356; 2018: 274)
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	1
Number of RCAs or SOEs completed during the last six (6) months.	1
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	5
List all corrective actions identified in the preceding field and note their status and due dates.	Action Item #1: Inclusion of psychiatrist in overall plan of care for high level cases and having documentation to support this inclusion; In progress/monitoring phase: DUE 6/28/19 Action Item #2: Management of mental health cases where detainees are not engaging in the assessment; In progress/monitoring phase; DUE 6/28/19 Action Item #3: Addressing possibly extending suicide watch based on finding high risk device that coud be used for to commit suicide. Identification of rope as suicidal ideation with plan and not a gesture. In progress/monitoring phase: DUE: 6/28/19 Action Item #4: Depression Screening; Mental Health Provider reviewing RN sick call notes for mental health related issues will address differential diagnosis using symptoms per DSM V; In progress/monitoring phase; DUE 6/28/19 Action Item #5: During DC Investigation outbrief, Investigators tasked ICE/GEO with fixing the process of Room Inspection Sheets findings; to be completed/monitored by GEO/ICE Custody
Risk Management Findings	Improved collaboration/communication between RM/FHPM during the event review process; FHPM referring cases for further review to SME (facility leader/HSA, Pharmacist and/or CD) as necessary. The use of Risk Stratification during the event review process is being implemented. FHPM/RM/RCS working to track/trend recurring identified process vulnerabilities.
Risk Management Deliverables	1) Facility leaders to support FHPM in her risk management activities to increase incident reporting volume

Schedules - Review Complete

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How many schedules were reviewed?	3
Of the schedules reviewed, how many had a legend to explain codes?	3
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	3
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	3
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	3
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	Please not the cTR vendor is permitting CTR staff to take paid holidays without any backfill of the loss of hours created. This will have adverse impact at sites that are at critical staffinglevels already.
Schedules Deliverables	No data reported

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	15
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	13
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	14
Of the segregation records reviewed, how many offered the patient daily sick-call services?	14
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	14
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	6
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	6
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	6
Segregation Records Findings	Facility received failed rating on one criteria above (ensuring medical segregation clearance); Of the 15 charts reviewed 2 did not have segregation clearance; Level 3 with threshold requirement of 100%. Otherwise facility passed all other criteria above.
Segregation Records Deliverables	(b)(5)

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Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	1
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	1
Were sick call services offered to detainees in segregation or other specialty housing units?	Yes
Segregation Encounters Findings	1) Detainee was housed in the MHU as a “Boarder Status;” however, this was not well understood as MHU 24 hour nursing care and charting continued. 2) Difficult to differential which medical log entries were for MHU RN Rounds versus RN Seg Rounds, RN Pill Line rounds and RN Insulin/Accucheck Rounds in the segregation log book.
Segregation Encounters Deliverables	(b)(5)

Shift Report and Time Cards - Review Complete

Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	Yes
Shift Report and Time Cards Findings	1, CTR staff are not punching in and out for lunch due to the programming of the time clock in use. 2. Shift reports ae well represented and it is thought that all staff report.
Shift Report and Time Cards Deliverables	None,

Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	0
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	0
Of the sick call records reviewed, how many included a full set of vital signs?	25
	20

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Of the sick call records reviewed, how many had a pain scale greater than 0?	
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	20
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	17
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	25
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	17
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	No data reported
Sick Call Records Findings	Facility received pass rating (met the threshold) for all sick call criteria mentioned above.
Sick Call Records Deliverables	No deliverables needed/recommended. Discussed chart review findings with facility leadership during onsite visit.

Staffing Information - Review Complete

(b)(5)

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(b)(5)

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(b)(5)

Suicide Watch Chart Review - Review Complete

How many suicide watch records were reviewed?	20
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	20
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	15
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	15
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	18
Of the suicide watch records, how many had a patient released from suicide watch?	20
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	20
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	18
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	20
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	15
Suicide Watch Pre-Audit Findings	1) Suicide Smock order via Special Needs form a) 2 of the 20 charts reviewed were identified as NOT having the suicide smock ordered via the Special Needs form b) 3 of the 20 charts could not

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	be be verified if the suicide smock was order via Special Needs form since the "Last D/C date" had been entered and you are not able to review previous Special Needs log. 2) Finger Food only order via Special Needs form a) 2 of the 20 charts reviewed were identified as NOT having the finger food ordered via the Special Needs form b) 3 of the 20 charts could not be be verified if the finger food only was order via Special Needs form since the "Last D/C date" had been entered and you are not able to review previous Special Needs log. 3) 2 of the 20 charts reviewed were identified as missing the daily MH or APP assessment/note causing a fail for this criteria 4) 2 of the 20 charts reviewed were identified as not having the Follow up SRA smartform completed during the suicide precautions (specifically when detainee being stepped down from suicide watch to constant watch); Facility appears to be implementing the suicide precaution Step-down protocol; however, the follow up SRA is not being completed daily until the detainee is discharge from Suicide precautions; Per IHSC Directive 07-04 Effective 4/30/19: 6-3.4 The BHP, CD or designee must complete a follow up SRA for patients on suicide precautions. (Suicide Precautions includes three levels (suicide watch, constant watch, and mental health observation) 5) 2 of the 20 charts reviewed was noted to be missing the Suicide Observation Checklist documentation (it is usually scanned into the detainee's record once detainee is discharged from suicide precautions); 3 of the 20 was asssigned as N/A since the detainee was still on suicide precautions at the time of the audit 6) At times difficult if the detainee was being placed on SW or CW during the initial SRA. "pt placed on suicide constant watch" 7) Incidental/Best Practice Indentified: a) Mental Health "Pink Card" self-referral process b) documentation in the note that there was good communication/notification from custody staff to medical regarding hiddent sharps found in detainee's room
Suicide Watch Pre-Audit Deliverables	1) Kudos - Continue good work with ensuring that detainees were evaluated by a MHP within 24 hours of being placed on suicide precautions 2) Remind staff to document Suicide Smock/Finger Foods only via Special Needs form 3) Remind staff (either MHP or medical) to document daily on detainee on suicide precaution 4) Kudos - continue to ensure that only a MHP/Physician is the one to discontinue the suicide precautions 5) Remind staff that Follow up SRA is to be documented/completed for detainee on all level of suicide precautions (step-down protocol: SW, CW, MHO) IHSC Directive 7-04; 6-3.3 and 6-3.4 6) Remind staff that the Suicide Observation Checklist is to be scanned into detainee's chart once he/she is discharged from suicide precautions 7) Encourage staff to be clear on the watch being ordered/implemented during the Initial SRA in their documentation: Suicide Watch vs Constant Watch vs Mental Health Observation. 8) Kudos - continue with MH "pink card" self-referral process and documentation of good communication/notification from custody to medical regarding self-injurious findings during custody searches.

Suicide Watch Observation - Review Complete

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How many patients are on suicide watch?	3
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	3
Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	3
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	3
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	3
Suicide Watch Encounters Findings	1) There were three (3) detainees on suicide precaution (constant watch) during this site visit observation 2) Good catch by nursing staff for identifying, documenting and notifying the CD/MHU provider that one of the 3 detainees on suicide precaution had been refusing his meals for the past few days without the detainee officially declaring a hunger strike. Detainee was identified as potentially dehydrated and was referred to the ER. Remind nursing staff to have high suspicion and know when to initiate the tracking and notification of a possible hunger strike to higher level of care. (detainee had been refusing meals since 7/5/19 approximately 7 missed meals) 3) Good Practice Noticed: Custody had the restrictive environment special needs form with the current order readily available/posted to ensure compliance.
Suicide Watch Encounters Deliverables	(b)(5)

Training - Review Complete

How many training folders were reviewed?	12
Of the training folders reviewed, how many had a HSD-500?	12
Of the training folders reviewed, how many had a signed position description ?	7
Of the training folders reviewed, how many were registered nurse training folders?	7
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	12
Of the training folders reviewed, how many had continuing medical education credits documented?	12
Training Findings	Signed position descriptions, HSA-500 and RN PE competencies housed in personnel record - acceptable place. Records maintainance immpeccable.
Training Deliverables	None

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Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	17
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	1
Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	3
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	4
Transfers Findings	Multiple TB-CM's not attached, Negative IGRA used to show TB status despite positive chest x-ray and treatment for TB, multiple cases where transfer summary stated that patient asn't being treated for TB even though they were. For general Transfer summaries, two detainees have medications listed but no medical conditions listed
Transfers Deliverables	No data reported
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	25
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	25

Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	12
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	12
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	12
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	0

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Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	12
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	12
Of the twelve workforce health files reviewed, how many had emergency contacts?	12
Are staff recordable injuries documented on Workforce Injury Tool?	No data reported
Workforce Health Files Findings	Ishihara - one staff in orientation and the Pharmacy Tech and Pharmacist did not have Ishihara's performed. The remainder of charts reviewed were out of complaince with the annual requirement-testing was out of date. Encouraged that pharmacy department be included as their color coding expiration process and identification of pills would require one to be able to discern different colors. Emergency contact info not in the file as per guidance. Best practice- site performs annual updates of the emergency contact sheets *Kudos*
Workforce Health Files Deliverables	(b)(5)

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	El Paso
Start Date	2017-08-21
End Date	2017-08-25
Status	Report Complete
Corrective Action Required?	No
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, MQMU	

Headquarters Review

Chief, Health Operations Unit Review Status	Review Complete
Chief, Medical Quality Management Unit Review Status	Review Deferred (Team Lead Only)
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Deferred (Team Lead Only)
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Deferred (Team Lead Only)
Chief of Staff Review Status	Review Deferred (Team Lead Only)
AD, IHSC Review Status	Review Deferred (Team Lead Only)

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	840.00
MHU Beds	9.00
Daily Adult Male Population	582.00
Daily Adult Female Population	167.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	28.00
Comments	NO DATA

Average Number of Encounters (Past 3 Months)

Prescreenings	471.00
Intake Screenings	479.00
Physical Examinations	354.00
Vitals/Labs	333.00
Sick Call	599.00
Pros/Imm	39.00
Acute	321.00
Chronic	98.00
Mental Health	106.00
Dental	19.00
Emergent/Urgent	139.00
MHU	448.00
Segregation	158.00
Admin	16.00
Transfers	399.00
Pill-Line Passes	4667.00
Prescriptions (Pill-line + KOP)	1126.00
Referrals/ER	87.00
Comments	NO DATA

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Staffing Information - Review Complete

(b)(5)

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Accreditation - Review Complete

Last ACA Accreditation	2015-11-04
Last ACA Findings	NO DATA
Last NCCHC Accreditation	2016-12-07
Last NCCHC Findings	Last NCCHC survey conducted December 7-9, 2016. The facility was found non-compliant in two essential standards, for which they have submitted corrective actions to NCCHC. There are 40 essential standards; 38 are applicable to this facility and 36 (95%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include: Essential Standards Not in Compliance J-E-06 Oral Care J-E-12 Continuity and Coordination of Care Essential Standards Not Applicable J-E-03 Transfer Screening J-G-03 Infirmary Care There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include: · Important Standards Not in Compliance None Important Standard Not Applicable J-C-08 Health Care Liaison J-E-06 Oral Care (E). Trained RNs complete the oral screening and provide instructions in oral hygiene and preventive oral education during intake. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. However, the dentist does not complete an oral examination within 12 months of detainees' admission. At the time of the survey, we found that 16 detainees had not received their annual oral screening, and were scheduled to be completed the following week. The standard is·not met. Corrective action is required for Compliance Indicator #3. An oral examination should be performed by a dentist within 12 months of admission. Documentation of corrective action is required in order to verify that oral examinations are being conducted and that they are done in this 12-month time frame. Acceptable documentation includes evidence of necessary policy and procedure changes, including staff training and results of a CQI process study assessing the timeliness of oral examinations for inmates within 12 months of admission. In order to receive accreditation, verification that this standard has been met is

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	required. J-E-12 Continuity and Coordination of Care During Incarceration (E). Clinician orders are evidence-based and implemented in a timely manner. Deviations are clinically justified, documented and shared with the patient. Patients receive treatment and diagnostic tests ordered by clinicians, who discuss such care with them. When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard. The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations (the Bureau of Prisons). However, while the clinician review diagnostic tests in a timely manner, they are not appropriately acted upon, nor are treatment plans modified as clinically indicated. The clinicians review, but do not always act upon, the recommendations of specialty consultants in a timely manner. Chart reviews are not of sufficient frequency and number to .assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is not met. Corrective action is required for Compliance Indicators #3. #7, and #9. All aspects of care should be coordinated and monitored from admission to discharge. Diagnostic tests should be reviewed by the clinic;:ian in a timely manner. Recommendations from specialty . consultations should be reviewed and acted upon by clinicians in a timely manner. Chart reviews should be done to assure that appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health and nursing. Acceptable documentation includes a plan by the RHA on how all aspects of this standard will be corrected. The plan should include necessary policy and procedure changes as well as evidence of training for appropriate staff. In addition, a CQI process study that evaluates the continuity and coordination of care following the implementation of the corrective action plan should be included. The CQI study should include a sufficient number of examples to demonstrate compliance with the standard. In order to receive accreditation,' verification that this standard has been met is required.
Last PBNDS Accreditation	2016-12-13
Last PBNDS Findings	

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	No findings for medical on last PBNDS visit. Next audit is 12/12/17
Comments	NO DATA

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	11.00
Is there a local SOP for managing grievances?	Yes
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	7.00
Number of informal grievances.	4.00
Findings	The role is being fulfilled by LT (b)(6); (b)(7)(C) and LT (b)(6); (b)(7)(C) but is being transitioned to LT (b)(6); (b)(7)(C)
Deliverables	NO DATA

Risk Management - Review Complete

Trends	Facility reported 3 incident reports during the 3rd quarter of FY 2017. No trends noted.
Number of active RCAs/SOEs	0.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	Yes
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	2.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	No - See findings below.
Findings	Nurses are documenting once pill line is complete.
Deliverables	None

AMERICAN OVERSIGHT

Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	Yes
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	Yes
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	Yes
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	N/A - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	Yes
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	No - See findings below.
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	N/A - See findings below.
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	"Safety Data Sheets (SDS)" folder as current one still says MSDS. Keep contents updated
Deliverables	(b)(5)

AMERICAN OVERSIGHT

Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	3.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	3.00
Number of psychotropic consent forms among the identified consent forms.	4.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	4.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	Two dental extraction procedures did not have consent forms.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	20.00
Out of the transfers reviewed, how many had a positive chest X-ray?	1.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	0.00
Out of the transfers reviewed, how many have active TB?	0.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	3.00
Number of transfers with medication instructions clearly provided.	5.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) Transfer summary CXR date documented wrong CXR completion date as 12/30/16 should be 11/25/16 as indicated on transfer summary scanned in eCW. (b)(6); (b)(7)(C) Transfer summary CXR date documented wrong CXR completion date as 4/26/17 should be 4/27/17 as indicated in eCW. (b)(6); (b)(7)(C) - Transfer summary CXR date documented wrong CXR completion date as 4/09/17 should be 4/12/17 as indicated in eCW. (b)(6); (b)(7)(C) Transfer summary CXR date documented wrong CXR completion date as 4/18/17 should be 4/19/17 as indicated in eCW. (b)(6); (b)(7)(C) - TB suspect - Transfer summary CXR indicates negative results with date of 4/27/17; should indicate "positive screening for active TB" with date of 4/28/17; no indication of negative AFB lab results. Also indicated "NA for question "Is detainee being treated for active TB disease"; however, RIPE medications listed.

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Deliverables	NO DATA

Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	25.00
Number of prescreens triaged according to prescreen policy.	20.00
Number of prescreens that used a translator.	1.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	1.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	24.00
Number of prescreens with documentation completed in eCW prior to intake screening.	10.00
Findings	Out of 25 pre-screens reviewed, 20 were triaged per pre-screen policy; 5 were not. Out of 25 pre-screens reviewed, 10 had documentation completed in e-CW prior to Intake screening; 15 had documentation completed in e-CW after the Intake screening
Deliverables	NO DATA

AMERICAN OVERSIGHT

Prescreening Observations - Review Complete

Number of prescreen encounters observed.	2.00
Number of prescreen encounters observed that allowed for patient privacy.	2.00
If privacy was not provided, where was the prescreen performed?	NO DATA
Number of prescreen encounters that used language services.	0.00
Number of prescreen encounters completed within two hours of arrival.	2.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	2.00
Number of prescreen encounters prioritized.	2.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	0.00
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	1.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	1.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	24.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	24.00
Of the intake screening records, how many were TB negative?	24.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	7.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	0.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	0.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	6.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	5.00
Number of intake screenings reviewed by an RN or above within 24 hours.	2.00
Findings	Of the 25 Intakes reviewed: 24 had TB clearance noted. Of the 24 charts that had TB clearance noted, seven (7) were signed, dated and stamped by a RN or higher. One (1) chart did not have TB clearance noted under the Labs, Diagnostic Imaging, or Scanned Docs tabs within e-CW. However, a note within the Intake Screening by the LV, indicates: "TB prophy refused Normal CXR 11/01/2016" Six had clinically signficant findings; One of those six charts indicated the detainee had a history of hyperlipids, but the detainee's Intake was coded as normal 3 Intake screenings were conducted by an LVN, thus requiring confirmatory sign-off by a RN or higher within 24 hrs. Of those three charts, one did not have confirmatory sign-off at all by a RN
Deliverables	NO DATA

AMERICAN OVERSIGHT

Intake Screening Observations - Review Complete

Number of intake screenings observed.	7.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	7.00
Number of intake screening observations where a full set of vital signs were taken.	7.00
Number of intake screening observations that used language services.	1.00
Of the intake screening observations that used language services, how many were appropriately conducted?	1.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	7.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	7.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	None.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	25.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	25.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	25.00
Number of chronic care encounters with psychiatric medications.	5.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	5.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	5.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	0.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	24.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	25.00
Findings	(1) chart without global alert.

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Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	1.00
Number of chronic care encounters observed that utilized language services.	0.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	0.00
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	7.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	7.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	5.00
Of the physical examinations with pain assessment, how many were addressed?	5.00
Number of physical examinations with clinically significant findings.	25.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	25.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	24.00
Number of physical examinations for females.	10.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	10.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	0.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	0.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	10.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	10.00
Findings	(1) chart with MD signature >7 days for PE-C.
Deliverages	NO DATA

Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	3.00
Number of physical examination encounters with a full set of vital signs taken.	3.00
Number of physical examination encounters observed that were completed within 14 days.	3.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	A chaperone sign is posted in the general clinic, but not in each room that conducts patient care. Reommendation: Post chaperone and I speak in any room that conducts patient care. Ensure they are placed in an area where the detainees and see them when they first come into the exam room and clinic.
Deliverables	None

AMERICAN OVERSIGHT

Sick Call Review - Review Complete

Number of sick call encounters reviewed.	25.00
Number of sick call encounters where the encounter was the third time that the patient has complained about the same issue.	0.00
Of the sick call encounters where the encoutner was the third time that the patient has complained about the same issue, how many were referred to a provider?	0.00
Number of sick call encounters with a full set of vitals including pain raiting and weight.	25.00
Number of sick call encounters with a pain scale greater than 0.	14.00
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?	13.00
Number of sick call encounters where nursing protocols/guidelines are referenced by name in the documentation.	23.00
Number of sick call encounters where the reason is documented in the "Reason" field.	25.00
Number of sick call encounters where the reason for the visit was from an approved category.	25.00
Number of sick call encounters addressed by a nurse.	24.00
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25.00
Findings	NO DATA
Deliverables	NO DATA

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Sick Call Observations - Review Complete

Does the facility have a defined process in place addressing sick call services?	Yes
Is the facility using a team-based approach for sick call?	Yes
Was sick call offered to detainees in segregation	Yes
For detainees that were not seen in segregation, is there a documented note in the medical record?	NO DATA
Findings	Sick call is offered to detainees in seg but not documented
Deliverables	Document in log book of seg visits sick call being offered.

AMERICAN OVERSIGHT

MHU 23 Hour Observation Review - Review Complete

Number of MHU 23 hour observation records reviewed.	
Number of MHU 23 hour observation records with admission encounters.	7.00
Number of MHU 23 hour observation records with discharge encounters.	6.00
Number of MHU 23 hour observation records with mental health and physical conditions with provisional diagnosis provided on admission.	7.00
Number of MHU 23 hour observation records with telephone order admission.	3.00
Number of MHU 23 hour observation records with telephone order admission that were signed by a provider within 48 hours.	0.00
Number of MHU 23 hour observation records labeled "Observation".	0.00
Findings	1) None of the charts were Labaled as "Observation" under reason of the note 2) When RN receives telephone order to place a detainee in MHU for 23 Hours Observation RN needs to send a Telephone encounter to the provider issuing the order 3) One case was noted where a detainee was placed/admitted to MHU for 23 hours observation by a provider for complaints of chest pain but was discharged the following day by the MHU RN without a MLP evaluation or a verbal order/consultation from a provider.
Deliverables	NO DATA

AMERICAN OVERSIGHT

MHU Full Admission - Review Complete

Are all patients within sight or hearing of a qualified health professional?	NO DATA
Number of nurses in the MHU at time of observation.	0.00
Number of patients in the MHU at time of observation.	0.00
Number of MHU full admission records reviewed.	23.00
Number of MHU full admission records with admission encounters.	22.00
Number of MHU full admission records with discharge encounters.	21.00
Number of MHU full admission records with mental health and physical conditions with provisional diagnosis provided on admission.	23.00
Number of MHU full admission records with no PE within the past year.	17.00
Of the MHU full admission records with no PE within the past year, how many had a PE completed during MHU admission?	5.00
Number of MHU full admission records with acuity level assigned.	22.00
Number of MHU full admission records with all medications placed on pill line.	20.00
Number of MHU full admission records with 24 hour chart reviews everyday.	23.00
Number of MHU full admission records for patients in segregation for medical overflow.	0.00
Of the MHU full admission records for patients in segregation for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0.00
Number of MHU full admission records with a nursing care plan.	14.00
Of the MHU full admission records with a nursing care plan, how many records indicate that the plan was addressed and reviewed daily?	14.00
Number of MHU full admission records where patient education was provided daily (e.g., admission education, daily plan of care).	23.00

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Number of MHU full admission records with mental health diagnoses.	4.00
Of the MHU full admission records with mental health diagnoses, how many records indicate that the patient was assessed on initial admission, re-evaluated in seven days, and every seven days thereafter?	4.00
Number of MHU full admission records without mental health diagnoses.	19.00
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days?	0.00
Findings	1) Overall good MHU documentation 2) 9 charts noted without nursing care plan 3) Remind providers except for rescue inhalers/Nitro/some topical medications all other Medications must be ordered as DOT while in MHU 4) When RN receives Telephone order to Admit or Discharge a detainee from MHU the RN needs to send the Telephone Encounter to that provider 5) Several charts noted to be missing the daily MHU Provider Rounds documentation/notes (gaps in MHU Provider Rounds noted) unsure if this is site specifically approved practice 6) Remind Behavioral Health Providers that if a detainee is admitted to MHU over 30 days without a Mental health diagnosis the detainee must be assessed by a BHP every 30 days (Detainee was admitted to MHU Isolation room on 5/30/17 and discharged on 7/27/17 but was never seen by a BHP)
Deliverables	NO DATA

AMERICAN OVERSIGHT

Suicide Watch Review - Review Complete

Number of suicide watch records reviewed.	2.00
Number of suicide watch records where the patient was evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide watch.	1.00
Number of suicide watch records where the patient was assessed to determine if a suicide smock was medically indicated.	1.00
Number of suicide watch records where the need for finger foos was annotated.	1.00
Number of suicide watch records where a daily mental health assessment was conducted and documented by a mental health or mid-level provider.	1.00
Number of suicide watch records where the patient was released from suicide watch by a mental health provider or physician.	1.00
Number of suicide watch records where a suicide risk assessment was conducted prior to release from suicide watch.	1.00
Number of suicide watch records where checks were conducted and documented at least every eight hours by clinical staff.	1.00
Number of suicide watch records where checks were conducted and documented at least every 15 minutes by custody staff (IHSC form uploaded and within record).	1.00
Findings	1. One Detainee was referred to an inpatient hospitalization. 2. There was one detainee on suicide watch when we arrived.
Deliverables	NO DATA

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Suicide Watch Observation - Review Complete

Number of patients on suicide watch.	1.00
Number of patients on suicide watch with nursing assessment performed within the past 8 hours.	1.00
Number of patients on suicide watch with 15 minute checks being performed on a staggered schedule.	1.00
Number of patients on suicide watch with an assessment by a mental health or mid-level provider within the last 24 hours.	1.00
Number of patients on suicide watch with restrictive environment compliant with current orders (e.g., smock, finger food, activity, etc).	1.00
Findings	None
Deliverables	None

AMERICAN OVERSIGHT

Hunger Strike - Review Complete

Number of hunger strike records reviewed.	0.00
Number hunger strike records with I&O's tracked via eCW flowsheet (approved eCW form included).	0.00
Number of hunger strike records which indicate that the patient was educated with documentation on the adverse effects of a hunger strike.	0.00
Number of hunger strike records which indicate that the patient was evaluated by a mental health provider.	0.00
Number of hunger strike records with complete orthostatic vital signs, height, weight, urinalysis, mental health evaluation, and physical assessment during the initial evaluation.	0.00
Number of hunger strike records with orthostatic vital signs including weight taken every 24 hours.	0.00
Number of hunger strike records that were discontinued by the Clinical Director or a physician.	0.00
Number of hunger strike records with special needs.	0.00
Of the hunger strike records with special needs, how many records indicate that the needs were addressed?	0.00
Findings	No hunger strikes in the last 7 months
Deliverables	NO DATA

AMERICAN OVERSIGHT

Segregation - Review Complete

Number of segregation records reviewed.	25.00
Number of segregation records that indicate the patient was medically cleared for segregation.	23.00
Number of segregation records where daily segregation rounds by nursing are documented.	25.00
Number of segregation records where the patient was offered sick-call services daily (typically offered during rounds).	25.00
Number of segregation records where the patient's mental health status was evaluated at least every 30 days.	1.00
Number of segregation records where the patient was seen weekly by mental health.	14.00
Findings	1) overall good segregation documentation 2) Incidental finding with one case where the Intake was completed on 6/29/17 but PE-C completed on 7/14/17 Delay in getting PE completed otherwise good seg documentation 3) One case noted where two weekly mental health segregation rounds were not completed (Mental health segregation round on 5/31/17 then the next one wasn't until 6/20/17) otherwise good documentation 4) One case where the segregation clearance note was not documented 5) Majority of the charts reviewed the detainee was in Segregation for 1 day to less than 1 week therefore no weekly Mental health Segregation rounds were completed/indicated in those cases.
Deliverables	NO DATA

AMERICAN OVERSIGHT

After Hours Medication Review - Review Complete

Number of after hours medication records reviewed.	25.00
Number of after hours medication records with the patient's identification number documented.	25.00
Number of after hours medication records with medication order(s) documented in eCW.	25.00
Number of after hours medication records that were generated by a nurse as a telephone order.	3.00
Number of after hours medication records that were generated by a nurse as a telephone order and were signed by a provider.	3.00
Does the pharmacy have a reconciliation process?	Yes
Does the pharmacy follow the reconciliation process?	Yes
Findings	A random review was conducted of eight medications in the after hours cart. Seven out of eight medication counts were not accurate.
Deliverables	(b)(5)

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After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Are after hours medication orders documented as dispensed in eCW?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the night cabinet reviewed three times per week?	No - See findings below.
Are medications in the night cabinet within their use date (i.e., not expired)?	Yes
Findings	A random review was conducted of eight medications in the after hours cart. Seven out of eight medication counts were not accurate.
Deliverables	(b)(5)

Language Access Review - Review Complete

Number of language access records reviewed.	25.00
Number of records where the patient was asked what language they speak.	25.00
Number of records where the patient's primary langauage or languag of choice is documented in their medical record.	25.00
Number of records where the translator use was addressed and documented (interpreter name or number, and language).	1.00
Reasons for why a translator was not used.	Of the 25 charts reviewed, one (1) indicated a translator was used. For the 24 charts were a translator was not used, the reason listed was "provider fluent in patient's native language."
Findings	NO DATA
Deliverables	NO DATA

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Language Access Observations - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Findings	"I Speak" posters are posted in main clinic waiting area but not posted in each exam room. Facility leadership stated they had hardship in securing the "I Speak" posters; HQ will assist in securing these for facility. There is currently no TDD/TTY access at the facility. There is access to sign language interpretors.
Deliverables	NO DATA

AMERICAN OVERSIGHT

Diagnostic Services - Review Complete

Are on-site diagnostic services (laboratory and radiology) certified or licensed to provide those services?	Yes
Is there a procedure manual for each service provided?	Yes
Does each manual include protocols for the calibration of testing devices to ensure accuracy.	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are all aspects of the CLIA-waived standards addressed by written policy and defined procedures?	Yes
Are invoices from LabCorp or other radiology companies reconciled?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
Are radiation exposure reports reviewed quarterly?	Yes
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Are there safety checks for biomedical and diagnostic equipment?	No - See findings below.
Findings	Last biomedical and diagnostic equipment check was 5/16; facility leadership is fully aware of expiration date and need for annual check; however, they do not currently have any funding to pay for services - they have requested funds to secure safety checks before expiration date but have not yet received funds.
Deliverables	A call was placed to RMU requesting STAT fullfillment of funding request for facility so they could secure safety checks immediately and be up to date. Limited funding drop was completed the following day by HQ and facility is scheduling appointment to rectify deficiency.

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Log Books - Review Complete

Number of refridgerator temperature logs reviewed.	46.00
Number of refridgerator temperature logs that are up to date.	46.00
Number of refridgerator temperature logs that are out of range.	0.00
Of the refridgerator temperature logs that are out of range, how many logs have documentation of action taken?	0.00
Are the sharps counts accurate?	Yes
Are two signatures present for each shift change on the sharps counts?	Yes
Are the narcotic counts accurate?	Yes
Are two signatures present for each shift change on the narcotics counts?	Yes
Are the crash cart/bag and AEDS checked daily and on every shift?	Yes
Are cleaning logs present in the MHU and up to date?	NO DATA
Findings	NO DATA
Deliverables	NO DATA

AMERICAN OVERSIGHT

Daily Assignment Sheets - Review Complete

Number of daily assignment sheets reviewed.	90.00
Number of daily assignment sheets completed and archived .	90.00
Number of daily assignment sheets with one emergency team identified per shift.	2.00
Number of daily assignment sheets with appropriate scheduling changes (staffing, leave, call outs, etc).	23.00
Number of daily assignment sheets with clinic inspection completed and signed.	90.00
Are detainee referrals documented?	Yes
Findings	Only two DAS did not have an emergency team identified = 2.2%
Deliverables	None

Shift Reports and Time Cards - Review Complete

Are reports held on time?	Yes
Is there at least one representative from each department?	Yes
Is there a time card for each contract employee?	Yes
Are lunch hours reflected on the time card?	Yes
Are written changes verified (initials, signature) by the HSA or AHSA(s)?	Yes
Findings	None
Deliverables	None

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Meetings - Review Complete

Out of the two previous staff meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous public health, safety, and preparedness meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous quality improvement meetings, how many were conducted at the appropriate time and properly documented?	2.00
Out of the two previous ICE/HSA meetings, how many were conducted at the appropriate time and properly documented?	2.00
Findings	None
Deliverables	None

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Personnel Files - Review Complete

Number of PHS officer personnel files reviewed.	7.00
Number of federal civil service employee personnel files reviewed.	1.00
Number of contractor personnel files reviewed.	17.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Is all current malpractice insurance information for contractors up to date?	N/A - See findings below.
Of all personnel file records reviewed, how many records are for priveleged staff (physician, psychiatrist, psychologist, dentist, and social worker)?	3.00
Of the personnel file records for priveleged staff, how many are current?	3.00
Number of personnel files with current and signed Health and Ability form.	21.00
Number of personnel files with a signed statement of confidentiality (one time).	25.00
Number of personnel files with a signed statement of risks and responsibility (one time).	25.00
Number of personnel files with a signed statement of acknowledgement of understanding of local, national, and residential standards (one time).	25.00
Number of personnel files with a signed release of information form (one time).	25.00
Findings	A lot of outdated forms that still have DIHS present and "Draft" watermarks. Four charts had outdated Health and Ability Forms. HSA was briefed.
Deliverables	None

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Credentialing Files- Review Complete

Number of PHS officer credentialing files reviewed.	7.00
Number of federal civil service employee credentialing files reviewed.	1.00
Number of contractor credentialing files reviewed.	17.00
Does the facility have a process for tracking requirements electronically?	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of credentialing files with health statements.	25.00
Number of credentialing files with current, valid, and unrestricted license.	24.00
Number of credentialing files with license primary source verification.	24.00
Number of credentialing files with documentation of primary education.	24.00
Number of credentialing files with education primary source verification.	24.00
Number of credentialing files reviewed for physicians or psychiatrists.	1.00
Number of physician or psychiatrist credentialing files with documentation of residency.	1.00
Number of credentialing files reviewed for board certified physicians or psychiatrists.	1.00
Number of board certified physician or psychiatrist credentialing files with documentation of board certification.	1.00
Number of credentialing files with a curriculum vitae or resume.	25.00
Number of PHS officer credentialing files with at least two years of evaluations (COERS).	7.00
Number of credentialing files with documented past or pending actions against a practitioner's license.	0.00
Number of credentialing files with current National Provider Data Bank information.	4.00
Number of credentialing files with scope of practice.	20.00
Number of credentialing files with personnel actions (positive or negative).	0.00

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Number of credentialing files with positive personnel actions (awards, recommendations, letters of appreciatio, etc).	5.00
Number of credentialing files with negative personnel actions (letter of counseling, etc).	0.00
Number of credentialing files with a competency assessment or peer review.	1.00
Number of peer reviews reviewed.	1.00
Number of peer reviews completed per local policy (clinical performance, appropriate use of resources, technical skills, clinical judgment, performance improvement activites).	1.00
Number of peer reviews with corrective actions.	0.00
Number of peer reviews with corrective actions addressed.	0.00
Findings	El Paso has a GS MRT and her folder was reviewed as part of the random selection.
Deliverables	None

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Employee Health Files - Review Complete

Are employee health files kept separate from other files?	Yes
Is access to employee records limited to the compliance officer, HSA, and AHSA(s).	Yes
Is the "electronic tracker" up to date and complete?	Yes
Number of employee health files reviewed.	25.00
Number of employee health files with current TB (PPD or CXR) documentation.	25.00
Number of employee health files with current Hepatitis B vaccination or declination form.	25.00
Number of employee health files with current Ishihara Color Blind test (only required for personnel completing CLIA-waived lab testing).	25.00
Number of employee health files with current respirator medical clearance.	25.00
Number of employee health files with current respirator fit test.	25.00
Number of employee health files with emergency contacts.	25.00
Are employee recorable injuries documented on OSHA Form 301 and OSHA 300 Log?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Training - Review Complete

Number of training folders reviewed.	25.00
Number of training folders with HSD-500.	25.00
Number of training folders with a signed position description.	25.00
Number of registered nurse training folders reviewed.	17.00
Number of registered nurse training folders with RN Physical Exam Training.	17.00
Number of training folders with continuing medical education credits.	2.00
Number of training folders with BLS for health care providers or CPR and AED certification.	25.00
Number of radiation safetoy officer training folders with radiation safety training.	1.00
Findings	None
Deliverables	NO DATA

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizer available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented?	Yes
Findings	NO DATA
Deliverables	NO DATA

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Schedules - Review Complete

Number of schedules reviewed.	3.00
Number of schedules with a legend to explain codes.	3.00
Number of schedules with staff assigned 20 "shifts" per scheduling period.	3.00
Number of schedules with evenly distributed staffing throughout the week.	3.00
Number of schedules with provider coverage on weekend/holidays.	2.00
Number of schedules with actual work hours reflected for non-traditional shifts.	3.00
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Findings	M.D.'s time card is not displayed in holder with the remainder of the staff. AHSA stated the M.D. keeps her timecard in her office.
Deliverables	Submit a copy of M.D. time card x 3 months for evaluation.

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Facility	Review Day	Review Date	Day of the Week	Task
El Paso	**Day 1**	3/16/2018	**Friday**	**H.S.A. Coordinator to initiate the pre-audit (emails triggered to team members via SharePoint**
	Day 2	3/17/2018	Saturday	Weekend
	Day 3	3/18/2018	Sunday	Weekend
	Day 4	3/19/2018	Monday	Review of charts, documentation, previous audit results, etc. by all units
	Day 5	3/20/2018	Tuesday	Review of charts, documentation, previous audit results, etc. by all units
	Day 6	3/21/2018	Wednesday	Review of charts, documentation, previous audit results, etc. by all units
	Day 7	3/22/2018	Thursday	Review of charts, documentation, previous audit results, etc. by all units
	Day 8	3/23/2018	Friday	Review of charts, documentation, previous audit results, etc. by all units
	Day 9	3/24/2018	Saturday	Weekend
	Day 10	3/25/2018	Sunday	Weekend
	Day 11	3/26/2018	Monday	Team Lead & Assistant review of documentation in SharePoint
	Day 12	3/27/2018	Tuesday	Team Lead & Assistant review of documentation in SharePoint
	Day 13	3/28/2018	Wednesday	Team Lead & Assistant review of documentation in SharePoint
	Day 14	3/29/2018	Thursday	Team Lead & Assistant review of documentation in SharePoint
	Day 15	3/30/2018	Friday	Team Lead & Assistant review of documentation in SharePoint
	Day 16	3/31/2018	Saturday	Weekend
	Day 17	4/1/2018	Sunday	Weekend
	Day 18	**4/2/2018**	**Monday**	**Pre-audit meeting**
	Day 19	4/3/2018	Tuesday	Extension days for updates/revisions/additions to tool from units if needed
	Day 20	4/4/2018	Wednesday	Extension days for updates/revisions/additions to tool from units if needed
	Day 21	4/5/2018	Thursday	Extension days for updates/revisions/additions to tool from units if needed
	Day 22	4/6/2018	**Friday**	**Final review of pre-audit documentation by Team Lead & Assistant**
	Day 23	4/7/2018	Saturday	Weekend
	Day 24	4/8/2018	Sunday	Weekend
	Day 25	4/9/2018	Monday	Arrange travel/authorization for travel
	Day 26	4/10/2018	Tuesday	No tasks
	Day 27	4/11/2018	Wednesday	No tasks
	Day 28	4/12/2018	Thursday	No tasks
	Day 29	4/13/2018	Friday	No tasks
	Day 30	4/14/2018	Saturday	Weekend
	Day 31	4/15/2018	Sunday	Travel day
	Day 32	4/16/2018	**Monday**	**Onsite review. Establish close out meeting time. Brief facility tour.**
	Day 33	4/17/2018	Tuesday	Onsite review.
	Day 34	4/18/2018	Wednesday	Onsite review.
	Day 35	4/19/2018	Thursday	Onsite review / close out meeting.
	Day 36	4/20/2018	Friday	Travel day
	Day 37	4/21/2018	Saturday	Weekend
	Day 38	4/22/2018	Sunday	Weekend
	Day 39	4/23/2018	**Monday**	Team Lead & Assistant reviews the report for completion, **Schedule Post-Audit HQ Meeting** and assigns to Unit Chiefs for review via SharePoint.
	Day 40	4/24/2018	Tuesday	Unit Chief review
	Day 41	4/25/2018	Wednesday	Unit Chief review
	Day 42	4/26/2018	Thursday	Unit Chief review
	Day 43	**4/27/2018**	**Friday**	**Team Lead & Assistant reviews the report for completion and routes to Leadership via SharePoint.**
	Day 44	4/28/2018	Saturday	Weekend
	Day 45	4/29/2018	Sunday	Weekend
	Day 46	4/30/2018	Monday	Leadership review (all DADs and AD)
	Day 47	5/1/2018	Tuesday	Leadership review
	Day 48	5/2/2018	Wednesday	Leadership review
	Day 49	5/3/2018	**Thursday**	**Team Lead & Assistant reviews the report for completion via SharePoint.**
	Day 50	5/4/2018	Friday	Team Lead & Assistant review
	Day 51	5/5/2018	Saturday	Weekend
	Day 52	5/6/2018	Sunday	Weekend
	Day 53	5/7/2018	Monday	Team Lead & Assistant review
	Day 54	5/8/2018	**Tuesday**	**Link to final report will be routed to the facility H.S.A., RHSA, and MQM Compliance Monitoring Specialist via SharePoint**

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IHSC Health Systems Assessment

This report was automatically generated based on data in Sharepoint.

Report generated: undefined
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Assessment Information - Report Complete

Facility	El Paso
Site visit start date	2019-05-20
Site visit end date	2019-05-24
Fiscal Year	FY2019
Fiscal Quarter	Q3
Post-audit corrective action identified	No
Immediate corrective action identified	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	
On-Site Reviewers	
Post-Audit Reviewers	
Specialist, Medical Quality Management Unit	
Chief, Medical Quality Management Unit	

Headquarters Review

Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)

Facility Information - Review Complete

Facility HSA, AHSA, Nurse Manager, and FHPM	(b)(6); (b)(7)(C)

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(b)(7)(E)

Regional HSA	
Bed Capacity	840
MHU Beds	9
Daily Adult Male Population	615
Daily Adult Female Population	298
Daily Juvenile Male Population	0
Daily Juvenile Female Population	0
Average Length of Stay (Days)	38
Facility Information Comments	No comments.

Average Number of Encounters (Past 3 Months)

Prescreenings	765
Intake Screenings	870
Physical Examinations	432
Vitals/Labs	493
Sick Call	787
Pros/Imm	74
Acute	453
Chronic	76
Mental Health	128
Dental	60
Emergent/Urgent	154
MHU	819
Segregation	237
Admin	67
Transfers	407
Pill-Line Passes	5267
Prescriptions (Pill-line + KOP)	1198
Referrals/ER	132

Accreditation - Review Complete

Last ACA Accreditation	2018-11-05T05:00:00Z
Last ACA Findings	None
Last NCCHC Accreditation	2016-12-08T05:00:00Z
Last NCCHC Findings	There are 40 essential standards; 38 are applicable to this facility and 36 (95%) were found to be in compliance. One hundred

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percent of the applicable essential standards must be met. Our findings include: Essential Standards Not in Compliance J-E-06 Oral Care J-E-12 Continuity and Coordination of Care J-E-06 Oral Care (E). Trained RNs complete the oral screening and provide instructions in oral hygiene and preventive oral education during intake. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. However, the dentist does not complete an oral examination within 12 months of detainees' admission. At the time of the survey, we found that 16 detainees had not received their annual oral screening, and were scheduled to be completed the following week. The standard is·not met. Corrective action is required for Compliance Indicator #3.-An oral examination should be p rformed by a dentist within 12 months of admission. Documentation of corrective action is required in order to verify that oral examinations are being conducted and that they are done in this 12-month time frame. Acceptable documentation includes evidence of necessary policy and procedure changes, including staff training and results of a CQI process study assessing the timeliness of oral examinations for inmates within 12 months of admission. In order to receive accreditation, verification that this standard has been met is required. J-E-06 Oral Care (E). Trained RNs complete the oral screening and provide instructions in oral hygiene and preventive oral education during intake. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. However, the dentist does not complete an oral examination within 12 months of detainees' admission. At the time of the survey, we found that 16 detainees had not received their annual oral screening, and were scheduled to be completed the following week. The standard is·not met. Corrective action is required for Compliance Indicator #3.-An oral examination should be p rformed by a dentist within 12 months of admission. Documentation of corrective action is required in order to verify that oral examinations are being conducted and that they are done in this 12-month time frame. Acceptable documentation includes evidence of necessary policy and procedure changes, including staff training and results of a CQI process study assessing the timeliness of oral examinations for inmates within 12 months of admission. In order to receive accreditation, verification that this standard has been met is required.

Last PBNDS Accreditation	2018-12-11T05:00:00Z
Last PBNDS Findings	No data reported
Accreditation Comments	No data reported

After Hours Medication Chart Review - Review Complete

How many after hours medication log records were reviewed?	8
Of the after hours med log records reviewed, how many records documented the patient's identification number?	8

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Of the after hours med log records reviewed, how many records were generated by a nurse as a telephone order?	8
Of the records generated by a nurse as a telephone order, how many were signed by a provider within 24 hours of return for next work shift?	8
Is an After-Hours Cabinet (AHC) medication sign out log in place for the documentation of medications removed?	Yes
Is all the necessary information entered into the fields of the AHC sign out log?	Yes
After Hours Medication Chart Review Findings	No findings.
After Hours Medication Chart Review Deliverables	No deliverables.

After Hours Medication Observation - Review Complete

Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	Yes
Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	Yes
Is the after hours verbal medication order entered into eCW by the prescriber upon return to duty?	Yes
Is the after hours medication administration properly documented on the MAR or in the electronic health record?	Yes
Is the night cabinet, clean, stocked, and organized?	Yes
Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	Yes
After Hours Medication Encounters Findings	After hours process is comprehensive and complete. Tight controls are maintained by pharmacy and nursing/APPs adhere to the process.
After Hours Medication Encounters Deliverables	No deliverables.

Chronic Care Chart Review - Review Complete

How many chronic care records were reviewed?	25
Of the chronic care records reviewed, how many had a PE--Complex completed within two business days?	18
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List?	25
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	15
	15

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Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	
Of the chronic care records reviewed, how many detainees had psychiatric medications?	6
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	6
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days for chronic care management?	6
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	15
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	12
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	10
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days ?	10
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	15
Chronic Care Records Findings	THE DETAINEE WAS SEEN FOR CH IN A TIMELY MANOR AND MOST OF THE TIME EXCEEDED PROTOCOL HOWEVER JUST NOT STATED (TIME FRAME) THERE WERE SEVERAL CH IDENTIFIED DURING S/C
Chronic Care Records Deliverables	IN REASON FOR CH INDICATE F/U MONTH 2 OR WEEK2

Chronic Care Observation - Review Complete

How many chronic care encounters were observed?	4
Of chronic care encounters observed, how many were considered stable patients?	4
Of the stable patients observed, how many were completed within the appropriate timeframe?	4
Of chronic care encounters observed, how many were considered unstable patients?	0
Of the unstable patients observed, how many were completed within the appropriate timeframe?	0
Of the chronic care encounters observed, how many had a treatment plan?	4
Chronic Care Encounters Findings	A provider read patient education material to detainee regarding condition and treatment options. She answered questions regarding not treating condition.

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Chronic Care Encounters Deliverables	None

Consent Forms Chart Review - Review Complete

How many consent forms were reviewed?	25
Of the consent forms reviewed, how many were general consent forms?	10
Of the general consent forms reviewed, how many were complete?	9
Of the consent forms reviewed, how many were dental consent forms?	6
Of the dental consent forms reviewed, how many were complete?	6
Of the consent forms reviewed, how many were psychotropic consent forms?	9
Of the psychotropic consent forms reviewed, how many were complete?	9
Consent Forms Findings	One General Consent was not found in detainee chart.
Consent Forms Deliverables	No deliverables.

Daily Assignment Sheets - Review Complete

How many daily assignment sheets were reviewed?	10
Of the daily assignment sheets reviewed, how many were archived appropriately?	10
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	10
Daily Assignment Sheets Findings	Daily Assigment sheet are completed electronically. Therefore, El Paso's archieving process is automatic.
Daily Assignment Sheets Deliverables	No deliverables.

Diagnostic Services - Review Complete

Are laboratory services provided in adherence with CLIA Waived testing?	Yes
Is there a current certificate for CLIA-waived testing?	Yes
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	Yes
	Yes

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Is there documentation of a quarterly (monthly for declared pregnancies) review of the dosimetry report by the HSA or Compliance Officer?	
Are staff seen wearing dosimeter badges while performing radiography services or while working in an area with radiation producing equipment?	Yes
Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	Yes
Diagnostic Services Findings	None
Diagnostic Services Deliverables	None

Emergency Preparedness and Response Observation - Review Complete

Is there documentation showing completed date and time of man-down drills?	Yes
Is there documentation showing completed date and time of fire drills?	Yes
Is there documentation showing completed date and time of mass casualty drills?	Yes
Are clinic staff trained on emergency equipment?	Yes
Do emergency scenarios vary?	Yes
Is it evident that the emergency incident was either an actual event, full drill, or table top exercise?	Yes
Is there a system in place to distribute an after-action report to all staff?	No
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event ?	Yes
Emergency Preparedness and Response Findings	1. Man Down and Fire Dirlls are completed per policy with documentation to support. However, the forms used do not clearly identify if the scenario is actual, drill, or table top. 2. Suggested to incorporate suicide scenarios quarterly to ensure staff are aware of how to obtain cutdown tool. 3. Communicates the results of any AAR during shift report. However, not captured in any minutes. Recommendation: Always create documentation to prove you are closing the loop. In this case, capturing the AAR in the monthly staff meetings.
Emergency Preparedness and Response Deliverables	(b)(5)

Environmental Health Observation - Review Complete

	Yes

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Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	
Are hazardous chemicals, including cleaning supplies, labeled and securely stored?	Yes
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with CO/HSA Signatures or designee) to show corrective action with completion date?	No
Do Airborne Isolation and Inspection (AII) rooms requiring transmission based precautions have appropriate signage for the required precaution(s)?	Yes
Is documentation of daily checks on (AII) rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from February 1st through April 30th each year?	Yes
Environmental Health Findings	Daily, Weekly, Quarterly PHSP checks are being done. However, Daily PHSP Checklist was not being used. Initiated beginning May 2019 and will be used moving forward.
Environmental Health Deliverables	Daily PHSP Checklist: Produce 3 consecutive days for each month (May, June, and July) for a total of 9 NLY 1 AUG 19.

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL.	18
Is there a local SOP for managing grievances?	No
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0
Number of formal grievances.	17
Number of informal grievances.	0
Grievances Findings	Grievance process is solid. Numbers reflecting FY19 to date.
Grievances Deliverables	No deliverables.

Hunger Strike Chart Review - Review Complete

How many of hunger strike records were reviewed?	1
Of the hunger strike records reviewed, how many had with I&O's tracked in the health record?	1
	1

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Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	1
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a mental health provider?	1
Of the hunger strike records reviewed, how many had a complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form?	1
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	1
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	1
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care and offer was documented in patient's chart?	0
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	1
Hunger Strike Records Findings	The detainee arrived to the facility on day 6 of the hunger strike status. The detainee had appropriate care and monitoring; medical, nursing and behavioral health services were conducted. There was one fall-out however. The detainee was not provided an evaluation from a behavioral health provider after the hunger strike was discontinued. The detainee remained in MHU for 4 days post hunger strike status. Detainee left facility 3 weeks after the hunger strike status was discontinued.
Hunger Strike Records Deliverables	No data reported

Hunger Strike Observation - Review Complete

How many patients were on a hunger strike at the time of observation?	0
Of the patients on a hunger strike, how many was water available for?	No data reported
Of the patients on a hunger strike, how many were offered meals?	No data reported
Of the patients on a hunger strike who were offered food, how much food was offered?	No data reported
Of the food offered, how much of the food was eaten?	No data reported
Of the patients on a hunger strike, how many had special needs?	No data reported

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Of the special needs patients on a hunger strike, how many records indicated that the needs were addressed?	No data reported
Hunger Strike Encounters Findings	No detainees were on hunger strike at the time of the survey.
Hunger Strike Encounters Deliverables	No detainees were on hunger strike at the time of the survey.

Infectious Disease Prevention - Review Complete

Are hand washing equipment and hand sanitizers available in the clinic?	Yes
Are contact and outbreak investigations documented in the PHSP Unit reporting tool on SharePoint?	Yes
Is hand hygiene monitoring conducted and documented on the quarterly review?	Yes
Infectious Disease Prevention Findings	No findings.
Infectious Disease Prevention Deliverables	No deliverables.

Intake Screen Chart Review - Review Complete

How many intake screen records were reviewed?	25
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	25
Of the intake screen records reviewed, how many used a translator?	0
Of the intake screen records that used a translator, how many listed a translator name or ID number ?	0
Of the intake screen records that did not use a translator, how many provide a reason for not using a translator?	25
Of the intake screen records reviewed, how many records had a complete pain assessment using the pain scale indicator?	25
Of the intake screen records reviewed, how many records had a pain scale greater than 0?	0
Of the records with a pain scale greater than 0, how many were assessed?	0
Of the intake screen records reviewed, how many used the eCW Intake Screening template?	25
Of the intake screen records reviewed, how many had clinically significant findings?	4
Of the intake records with clinically significant findings, how many were referred appropriately?	4
Of the intake screen records reviewed, how many were reviewed by an RN or above within 24 hours?	4

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Intake Screen Records Findings	Of the 25 Intake screen records reviewed, six (6) of the intakes were completed by a LVN, thus requiring the review of a RN or higher, within 24 hours. Of those 6 intakes, four (4) of them met that requirement. Two (2) did not meet the requirement.
Intake Screen Records Deliverables	No data reported

Intake Screen Observation - Review Complete

How many intake screen encounters were observed?	5
Of the intake screen encounters observed, how many did the nurse review the prescreen and transfer paperwork prior to initiating the intake screening?	5
Of the intake screen encounters observed, how many included a full set of vital signs?	5
Of the intake screen encounters observed, how many used the eCW Intake Screening template?	5
Of the intake screen encounters that used the eCW Intake Screening template, how many were completed appropriately?	5
Of the intake screen encounters observed, how many was the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide?	5
Of the intake screen encounters observed, how many included security advice of special needs and housing disposition?	5
Intake Screen Encounters Findings	RNs completed all observed intake screenings.
Intake Screen Encounters Deliverables	None.

Language Access Chart Review - Review Complete

How many language access records were reviewed?	25
Of the language access records reviewed, how many indicate that patient was asked what language he or she speaks?	25
Of the language access records reviewed, how many document the patient's primary language or language of choice in his or her medical record?	25
Of the language access records reviewed, how many addressed and documented the use of a translator?	2
Of the language access records reviewed, how many did not use a translator?	23
Of the language access records that did not use a translator, how many documented reasons why a translator was not used?	5
Language Access Records Findings	No discrepancies

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Language Access Records Deliverables	No recommendations to review

Language Access Observation - Review Complete

Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	Yes
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	Yes
Language Access Encounter Findings	TDD/TYY located in MHU and the property of custody.
Language Access Encounter Deliverables	No deliverables.

Log Books - Review Complete

How many pharmacy refrigerator temperature logs were reviewed?	15
Of the pharmacy refrigerator temperature logs reviewed, how many have entries per shift for the past three months?	15
Of the pharmacy refrigerator temperature logs reviewed, how many refrigerator temperature logs are out of range?	0
Of the temperature logs that are out of range, how many logs have documentation of action taken and follow-up?	0
Are the sharps secured and the count accurate?	Yes
In review of the past 3 months of sharps counts, are two signatures present for each shift changes?	Yes
Are the narcotics secured with double lock and counts within the last 3 months accurate?	Yes
In review of past 3 months of controlled substance logs, are two signatures present for each shift change on the narcotics counts?	Yes
Are the urgent care cart/trauma bag and AEDs checked daily for content, signatures, AED functionality, and expiration for the past 3 months?	Yes
Log Books Findings	No findings.
Log Books Deliverables	No deliverables.

Medication Administration Observation - Review Complete

Is prepouring occurring?	No
How many medication administrations were observed?	10

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Of the medication administrations observed, how many times were nurses adhering to ALL six rights of medication administration?	10
Of the medication administrations observed, how many mouth checks were conducted?	10
Of the medication administrations observed, how many times did nurses document the medication administration immediately after the medication was administered?	10
How many MAR entries were observed?	10
Of the MAR entries observed, how many were complete?	10
Of the MAR entries observed, how many medication refusals were documented?	0
Of the identified medication refusals, how many refusals had accompanying eCW documentation ?	No data reported
Of the identified medication refusals, how many were high-risk medications?	No data reported
Of the identified high-risk medication refusals, how many times were providers notified of the refusal?	No data reported
Medication Administration Findings	At the time of the observation, there were no medication referrals. Pill line nurse was able to answer detainees' questions regarding treatment and follow up.
Medication Administration Deliverables	None.

Meetings - Review Complete

Of the two previous staff meetings, how many were conducted monthly and properly documented?	2
Of the two previous public health, safety, and preparedness meetings, how many were properly documented?	2
Of the two previous quality improvement meetings, how many were conducted quarterly and properly documented?	2
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	0
Meetings Findings	1. Governing Body meeting minutes includes both PHSP-related items and Quality Improvement. PBNDs requires the QA/QI minutes to be seperate. Recommendation: Seperate GB and QI minutes beginning FY19 Q3 2. ICE/HSA meetings (aka Stakeholder's Meeting) are conducted weekly and facilitated by ICE AFOD. AFOD does not take meeting minutes.
Meetings Deliverables	(b)(5)

MHU Full Admission Chart Review - Review Complete

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How many MHU full admission records were reviewed?	25
Of the MHU full admission records reviewed, how many had admission encounters?	10
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	18
Of the MHU full admission records without a documented PE, how many received a PE within 24 hours of admission to the MHU?	7
Of the MHU full admission records reviewed, how many had a nursing care plan?	14
Of the MHU full admission records with a nursing care plan, how many records indicate the plan was addressed and reviewed daily?	14
Of the MHU full admission records reviewed, how many had patient education provided daily?	14
Of the MHU full admission records reviewed, how many indicated detainee had an existing mental health diagnosis prior to admission?	4
Of the records that indicate that the detainee had a mental health diagnoses, how many received a mental health reassessment every seven (7) days, or more frequently, if indicated	3
Of the MHU full admission records reviewed, how many records did not have a mental health diagnoses?	21
Of the MHU full admission records without mental health diagnoses, how many records indicate the patient was assessed every 30 days by a MHP?	1
MHU Full Admission Records Findings	One of the 4 mental health admission refused to see mental health. Some admissions (without mental health diagnoses) were less than 30 days and did not require a BHP visit every 30 days.
MHU Full Admission Records Deliverables	No data reported

MHU Full Admission Observation - Review Complete

Are all patients within sight or hearing of a qualified health professional?	Yes
How many nurses are in the MHU full admission at the time of observation?	1
How many patients are in the MHU full admission at the time of observation?	0
How many MHU full admission patients have a 24-hour chart review everyday?	0
Of the MHU full admission records, were 24-hour charts completed appropriately?	No data reported

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How many MHU full admission patients have medications?	0
Of the MHU full admissions patients with medicaitons, how many have all medications placed on pill line?	0
MHU Full Admission Encounters Findings	At the time of observation, all MHU patients were discharged leaving zero.
MHU Full Admission Encounters Deliverables	No deliverables

Personnel and Credentialing Files - Review Complete

Does the facility have a process for tracking requirements electronically?	Yes
How many personnel and credentialing files were reviewed?	18
Of personnel and credentialing files reviewed, how many were PHS officers?	5
Of the PHS officer records, how mand had at least two years of evaluations (COERS)?	3
Of personnel and credentialing files reviewed, how many were federal civil service employees?	1
Of personnel and credentialing files reviewed, how many were contractors?	12
Of personnel and credentialing files reviewed, how many records are for privileged staff?	7
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	5
Of the LIP staff records reviewed, how many had personnel files records current?	5
Of the LIP staff records reviewed, how many had a competency assessment or peer review?	5
Of personnel and credentialing files reviewed, how many contained a current and signed Health and Ability form?	18
Of personnel and credentialing files reviewed, how many contained a signed statement of confidentiality?	18
Of personnel and credentialing files reviewed, how many contained a signed statement of risks and responsibility?	18
Of personnel and credentialing files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards?	18
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	18
Of personnel and credentialing files reviewed, how many contained current, valid, and unrestricted license?	15
	15

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Of personnel and credentialing files reviewed, how many contained documentation of primary education , license primary source, and annual verification?	
Of personnel and credentialing files reviewed, how many were reviewed for physicians or psychiatrists?	1
Of the physician or psychiatrist records, how many had documentation of residency?	1
Of the physician or psychiatrist records, how many were board certified?	1
Of the board certified physicians and psychiatrists, how many had documentation of board certification?	1
Of personnel and credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	18
Of personnel and credentialing files reviewed, how many had current National Provider Data Bank information?	8
Personnel and Credentialing Files Findings	All files were organized and uniformed. Reviewer needed AA to navigate the multiple folders (personnel, credentialing, health, training) as conflicting /contradicting information has been provided by HQ over the years. However, the upcoming plan of HQ retaining credentialing files for all field staff will prove to be beneficial and provide much needed uniformity and guidance for the field.
Personnel and Credentialing Files Deliverables	No deliverables.

Physical Exam Chart Review - Review Complete

How many physical exam charts were reviewed?	25
Of the physical exam charts reviewed, how many used language services?	2
Of the physical examinations that used language services, how many contained identification of the translator or interpreter?	2
Of the physical exam charts reviewed, how many were for juveniles?	0
Of the juvenile physical exam charts reviewed, how many were completed within 7 days of arrival to the facility?	0
Of the physical exam charts reviewed, how many were for adults?	25
Of the adult physical exam charts reviewed, how many PE-S's were completed within 14 days of arrival to the facility?	13
Of the physical exam charts reviewed, how many had a pain assessment?	25
Of the physical exam charts with pain assessment, how many were addressed ?	25
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	9

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Of the physical exam charts reviewed, how many were reviewed by an MD? PE-S within 14 days.	13
Of the physical exam charts reviewed, how many were for adult females?	7
Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	7
Of the adult female physical exam charts reviewed, how many had a record with a pap test offered?	0
Of the adult female physical exam charts reviewed, how many had a record where a pap test was not indicated?	25
Physical Exam Records Findings	None.
Physical Exam Records Deliverables	None.

Physical Exam Observation - Review Complete

How many physical exam encounters were observed?	8
Of the physical exam encounters observed, how many included a full set of vital signs?	8
Of the physical exam encounters observed, how many were completed within the specified timeframe?	8
Of the physical exam encounters observed, how many included a detainee request for a chaperone?	8
Of the physical exam encounters observed, how many had an abnormal vital sign?	2
Of the physical examination encounters observed with an abnormal vital sign, how many were addressed and/or referred to a higher level of care?	2
Of the physical exam encounters observed, how many indicated that a Snellen test was conducted during the examination?	8
Of the physical exam encounters observed, how many were properly designated as either PE-Complex or PE-Simple in accordance with the IHSC Directive on Health Assessments?	8
Of the physical examination encounters observed, how many were referred to the next level of care as directed by IHSC policy?	2
Physical Exam Encounters Findings	The team had good communication with the detainees. They took the time to explain things and to inform the detainee what to expect.
Physical Exam Encounters Deliverables	None.

Prescreen Observation - Review Complete

How many prescreen encounters were observed?	7

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Of the prescreen encounters observed, are language services being used during prescreen if appropriate?	Yes
Of the prescreen encounters observed, how many prescreen encounters had documentation completed in eCW prior to intake screening?	7
Of the prescreen encounters observed, how many prescreening encounters were prioritized to level one when clinically indicated based on self-reported history or objective findings?	1
Prescreen Encounters Findings	None
Prescreen Encounters Deliverables	None

Risk Management - Review Complete

Trends	No data reported
Number of active Root Cause Analyses(RCA)/Sequence of Events (SOE).	0
Number of RCAs or SOEs completed during the last six (6) months.	0
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0
List all corrective actions identified in the preceding field and note their status and due dates.	N/A
Risk Management Findings	No RCAs/SoEs, or CAPs for FY18 to present.
Risk Management Deliverables	No deliverables.

Schedules - Review Complete

How many schedules were reviewed?	5
Of the schedules reviewed, how many had a legend to explain codes?	5
Of the schedules reviewed, how many had staff assigned "40 hours per week" per scheduling period?	5
Of the schedules reviewed, how many had provider coverage on weekend/holidays?	5
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	5
Are there signed approvals for non-traditional shifts?	Yes
Is there a PDF copy each time a change was made to the schedule?	Yes
Schedules Findings	1. Non-shift approval request is due for renewal. Recommendation: Have the CC and NM collaborate to ensure all potential non-core

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(b)(7)(E)
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	shifts are requested. Send to HSA for concurrence. If HSA is in agreement, forward to RHSA for final approval. 2. PDF copies are made daily regardless of changes
Schedules Deliverables	No deliverables.

Segregation Chart Review - Review Complete

How many segregation records were reviewed?	25
Of the segregation records reviewed, how many indicate the patient was medically cleared for segregation?	24
Of the segregation records reviewed, how many indicate if daily segregation rounds by nursing are documented ?	21
Of the segregation records reviewed, how many offered the patient daily sick-call services?	25
Of the sick call services offered, how many were documented and noted whether patient accepted or denied sick call services?	25
Of the segregation records reviewed, how many patients had no history of a mental health diagnosis or mental health status was evaluated at least every 30 days?	22
Of the segregation records reviewed, how many patients had a history of a mental health diagnosis?	3
Of the patients with a mental health diagnosis, how many were seen weekly by Mental Health?	3
Segregation Records Findings	5 charts were missing one day of seg rounds (most were noted to be on 2/19/19). One note did not have a seg clearance noted.
Segregation Records Deliverables	No data reported

Segregation Observation - Review Complete

How many patients in segregation were observed in MHU full admission for medical overflow?	0
Of the patients in segregation observed in MHU full admission for medical overflow, how many records indicate that the patients were rounded on according to MHU policy?	0
Were sick call services offered to detainees in segregation or other specialty housing units?	No data reported
Segregation Encounters Findings	No patients in Seg at the time of observation.
Segregation Encounters Deliverables	N/A

Shift Report and Time Cards - Review Complete

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Are shift reports conducted?	Yes
Is there at least one representative from each department?	Yes
Are written changes verified (initials, signature) on time cards by the HSA or AHSA(s)?	No
Shift Report and Time Cards Findings	Not many changes are noted on the time cards. Recommendation: Con Coordinator or GTM to provide initials when changes are made. Reminded Con Coordinator & GTMs that time card is a legal document.
Shift Report and Time Cards Deliverables	No deliverables.

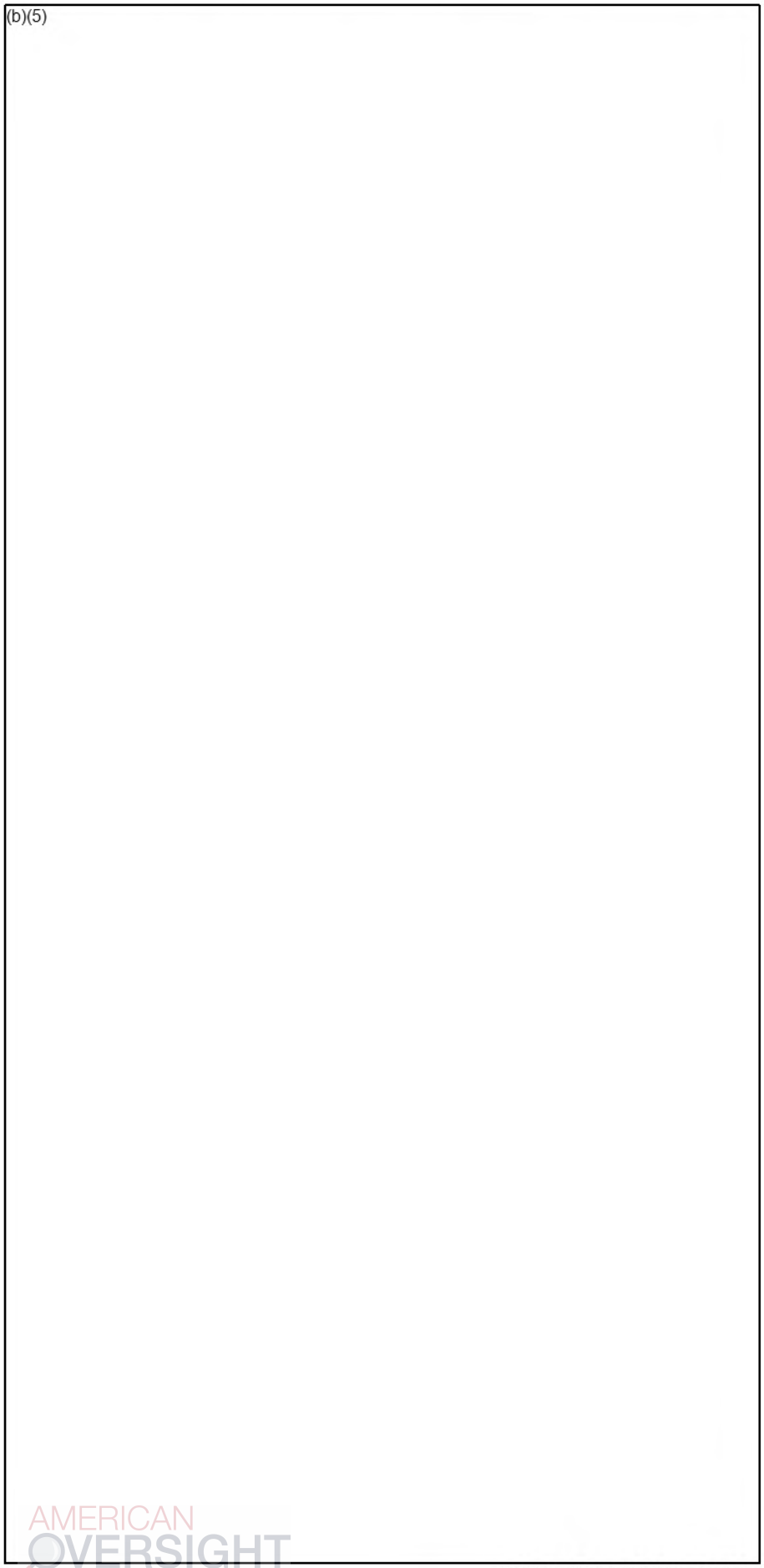
Sick Call Chart Review - Review Complete

How many sick call records were reviewed?	25
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?	2
Of the sick call records where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?	2
Of the sick call records reviewed, how many included a full set of vital signs?	24
Of the sick call records reviewed, how many had a pain scale greater than 0?	20
Of the sick call records with a pain scale greater than 0, how many indicated that the pain was addressed?	20
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?	18
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?	24
Of the sick call records reviewed, how many had the reason for visit from an approved category?	25
Of the sick call records reviewed, how many were addressed by a nurse?	25
Of the sick call records addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	25
Does the facility have a defined process in place addressing sick call services?	No data reported
Sick Call Records Findings	1) 7 of the 25 charts did not reference a RN guideline by name; "2008 rn guideline" was documented in several of the charts and others did not document/mention the RN guideline at all; otherwise good sick call documentation and referral to a provider as per RN sick call policy 2) Only 1 chart did not have a full set of vitals
Sick Call Records Deliverables	No data reported

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Staffing Information - Review Complete

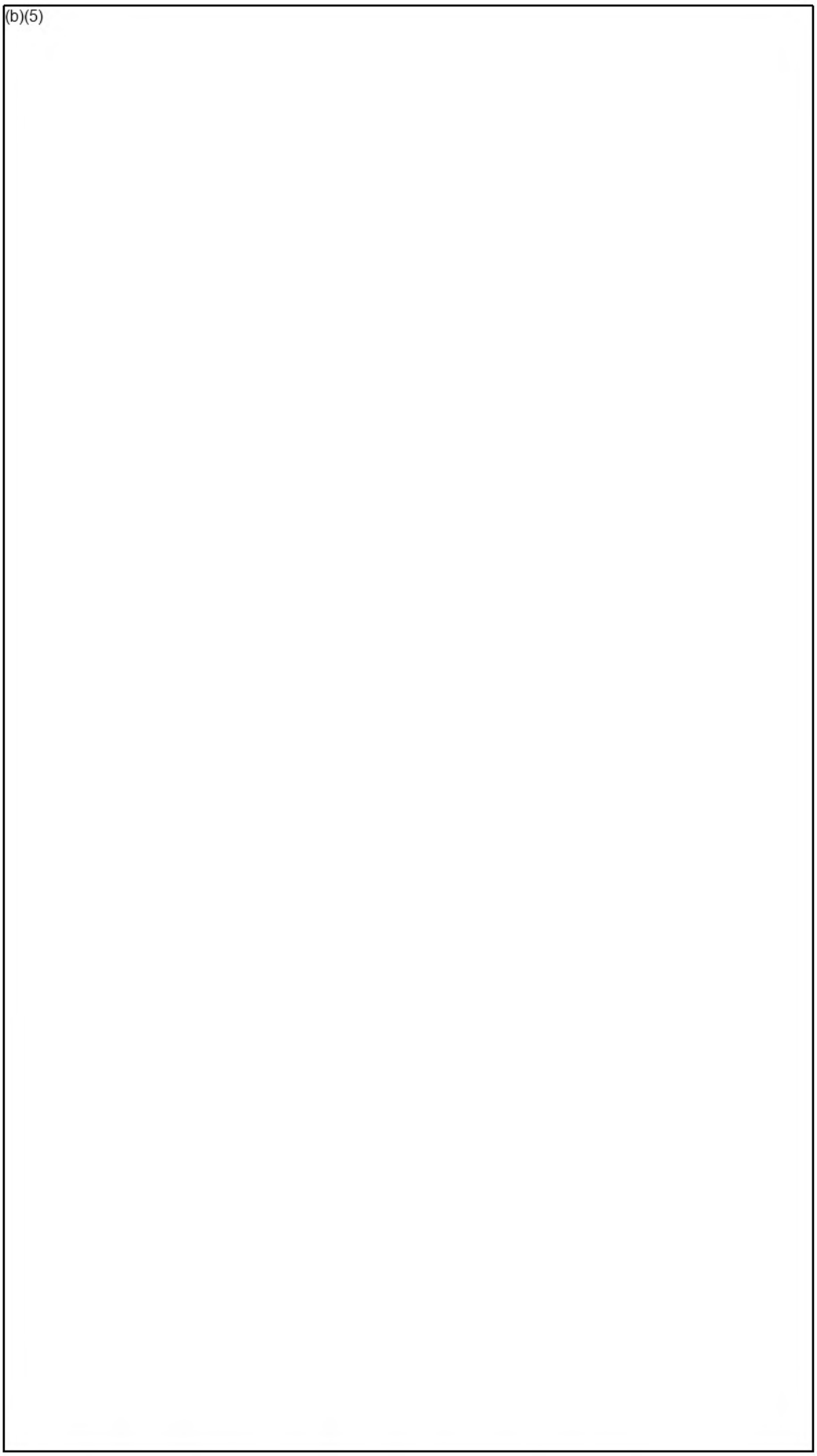
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(b)(7)(E)

(b)(5)



Suicide Watch Chart Review - Review Complete

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(b)(7)(E)

How many suicide watch records were reviewed?	
Of the suicide watch records, how many had a patient evaluated for suicide risk by a mental health profession or physician within 24 hours of being placed on suicide?	3
Of the suicide watch records, how many had a patient assessed to determine if a suicide smock was medically indicated via a Special Needs form?	3
Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	2
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a mental health or mid-level provider?	2
Of the suicide watch records, how many had a patient released from suicide watch?	3
Of the suicide watch records, how many had a patient released from suicide watch by a mental health provider or physician?	3
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	3
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by clinical staff?	1
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	0
Suicide Watch Pre-Audit Findings	Evening/night shift exceeded 8 hour documentation in eCW. 2 charts could not access special needs. Zero noted as to custody staff documenting 15 minute checks due to inproper filling in of form and duplicate forms for same day. 15 minute blocks were filled, but not correctly.
Suicide Watch Pre-Audit Deliverables	Comments on Excel sheet (b)(7)(E) Observation checklist 1/15 missing in scanned documents. 1/16 with year illegible, old checklist used with predetermined times. 1/16 CDO "MO" documented 179- unsure what that is, does not match options, CDO "MV" also documented 79- unknown option. (b)(7)(E) observation checkllist with initials only, no codes, duplicate days with different information. (b)(7)(E) missing signature with initials (NN) , "DO" are putting their id numbers with codes which makes it difficult to understand. Facility really just needs to educate their custody staff on how to use form and fill out properly. "DO" is deportation officer at many facilities, however custody staff appear to use same abbrevaition to designate themselves.

Suicide Watch Observation - Review Complete

How many patients are on suicide watch?	0
Of the patients on suicide watch, how many have a nursing assessment performed within the past 8 hours?	0
	0

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Of the patients on suicide watch, how many have 15 minute checks being performed on a staggered schedule?	
Of the patients on suicide watch, how many have an assessment by a mental health or mid-level provider within the last 24 hours?	0
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders?	0
Suicide Watch Encounters Findings	There were not any detainee on suicide watch at the time of the observation.
Suicide Watch Encounters Deliverables	None.

Training - Review Complete

How many training folders were reviewed?	18
Of the training folders reviewed, how many had a HSD-500?	18
Of the training folders reviewed, how many had a signed position description ?	18
Of the training folders reviewed, how many were registered nurse training folders?	4
Of the registered nurse training folders reviewed, how many documented RN Physical Exam Training?	4
Of the training folders reviewed, how many had continuing medical education credits documented?	No data reported
Training Findings	Continuing education documentation is not consistantly located in the same place due to conflicting infomration provided by HQ (maintaining multiple files/person). Credentialing system pending HQ modification. Therefore, no deliverables will be requested from the site until the HQ transition has occurred and process re-evaluated.
Training Deliverables	No deliverables.

Transfer Summary Chart Review - Review Complete

How many transfers were reviewed?	25
Of the transfers reviewed, how many outgoing transfers were authenticated appropriately (signed, stamped, and dated)?	25
Of the transfers observed, how many outgoing transfers were completed by an LVN or above?	25
Of the transfer summary records reviewed for TB status, how many correctly documented no TB treatment status?	3
Of the transfer summary records reviewed for TB status, how many incorrectly documented no TB treatment status? (TB meds listed??)	0

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Of the transfer summary records reviewed for TB status, how many correctly documented TB treatment status?	2
Of the transfer summary records reviewed for TB status, how many incorrectly documented TB treatment status? (Taking TB meds)	1
Transfers Findings	TB Findings: 2 out of 7 charts was correct for all areas. 1 out of 7 charts had incorrect information and 4 out of 7 TB charts did not have a transfer summary completed when the detainee left the facility, so an audit of the TB Transfer Summary could not be completed. General Transfer: No findings identified for general transfers. Four (4)out of 25 detainees had chronic medications. All four (4) were listed and labeled appropiately
Transfers Deliverables	No data reported
Of the transfer summaries reviewed, how many listed the detainee's chronic medical conditions appropriately?	25
Of the transfer summaries reviewed, how many had "clear medication instructions" documented appropriately?	4

Workforce Health Files - Review Complete

Are workforce health files kept separate from other files?	Yes
Is access to staff records limited to the compliance officer, HSA, and AHSA(s) and AA?	Yes
How many workforce health files were reviewed?	18
Of the twelve workforce health files reviewed, how many had past year's TB (PPD or CXR) documentation?	18
Of the twelve workforce health files reviewed, how many had a Hepatitis B vaccination or declination form?	18
Of the twelve workforce health files reviewed, how many had a yearly Ishihara Color Blind test?	18
Of the twelve workforce health files reviewed, how many had a yearly respirator medical clearance?	18
Of the twelve workforce health files reviewed, how many had a yearly respirator fit test?	18
Of the twelve workforce health files reviewed, how many had emergency contacts?	18
Are staff recordable injuries documented on Workforce Injury Tool?	Yes
Workforce Health Files Findings	No findings.
Workforce Health Files Deliverables	No deliverables.

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 09/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	NO	YES	N/A	YES
2		Opthalmology	NO	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Orthopedics	YES	YES	N/A	YES
5		Orthopedics	YES	YES	N/A	YES
6		Other	NO	YES	N/A	YES
7		General Surgery	NO	YES	N/A	YES
8		Orthopedics	NO	YES	N/A	YES
9		Cardiology	NO	YES	N/A	YES
10		Other	NO	YES	N/A	YES
		Total	3 / 10 30 %	10 / 10 100%	0 / 0 NaN%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	severe testicular pain/unable to void	YES	NO	YES	YES	NA
2		convulsions	YES	NO	YES	YES	YES
3		head trauma	YES	NO	YES	YES	YES
4		fractured finger	YES	NO	YES	YES	YES
5		neck injury	YES	NO	YES	YES	YES
6		R/O MI	YES	NO	YES	YES	YES
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			6 / 6 100 %	0 / 6 0 %	6 / 6 100 %	6 / 6 100 %	5 / 5 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

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DHS-ICE-20-0618-A-000788

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 9/20/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	severe hypertension	YES	NO	YES	YES	YES
2		potential overdose	YES	NO	YES	YES	YES
3		thoracic aortic aneurysm	YES	NO	YES	YES	YES
4		tachycardia, dehydrated	YES	NO	YES	YES	YES
5			NO	NO	NO	NA	NA
6			NO	NO	NO	NA	NA
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			4 / 4 100 %	0 / 4 0 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000789

HEALTH ASSESSMENT

DATE 3/6/2016 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	18 / 18 100 %	7 / 7 100 %	20 / 20 100 %	19 / 20 95 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

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HEALTH ASSESSMENT

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

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Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	NA	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	NA	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	NA	NA	YES	YES
2		YES	NA	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	NO
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	NA	YES
3		YES	NA	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	18 / 18 100 %	3 / 3 100 %	16 / 16 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV Bureau of Prison HIV guidel

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Recent Lab	YES	YES	YES	YES	YES
2		Medical Record	YES	NA	YES	YES	YES
3		Patient Interview	YES	YES	YES	YES	YES
4		Recent Lab	YES	YES	YES	YES	YES
5		Recent Lab	YES	YES	YES	YES	YES
6		Medical Record	YES	YES	YES	YES	YES
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		6 / 6 100 %	5 / 5 100 %	6 / 6 100 %	6 / 6 100 %	6 / 6 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000794

CHRONIC DISEASE – HIV

DATE 9/20/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV Bureau of Prison HIV guidel

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Patient Interview	YES	YES	YES	YES	YES
2		Medical Record	YES	YES	YES	YES	YES
3		Recent Lab	YES	YES	YES	YES	YES
4		Patient Interview	YES	YES	YES	YES	YES
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000795

CHRONIC DISEASE – HYPERTENSION

DATE 03/06/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? American Academy of Family Physicians and BOP H

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	N/A	N/A
6		YES	YES	N/A	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	10 / 10 100 %	10 / 10 100 %	6 / 6 100 %	9 / 9 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 09/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? American Academy of Family Physicians and BOP H

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		NO	N/A	N/A	N/A
6		NO	N/A	N/A	N/A
7		NO	N/A	N/A	N/A
8		NO	N/A	N/A	N/A
9		NO	N/A	N/A	N/A
10		NO	N/A	N/A	N/A
	Total	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	NO	YES	YES	YES	YES
2		NO	YES	YES	YES	YES
3		NO	YES	YES	YES	YES
4		NO	YES	YES	YES	YES
5		NO	YES	YES	YES	YES
6		NO	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		NO	YES	YES	YES	NA
9		NO	YES	YES	YES	YES
10		NO	YES	YES	YES	YES
	Total	1 / 10 10 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000798

LABORATORY TESTING

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NO
2		YES	YES	YES	YES	NO
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	NO
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	7 / 10 70 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000799

MEDICAL RECORDKEEPING PRACTICES

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☑ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Partial com	Partial compliance	Partial compliance	Partial compliance	Partial compliance
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Partial compliance	Partial compliance	Partial compliance	Partial compliance
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	Compliant	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	Compliant
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	Compliant	Compliant	NA	Compliant
Immunization records, where applicable	NA	NA	NA	Compliant	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	NA	NA	NA	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 9/20/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	NA	NA	Compliant
Flowsheets	Compliant	NA	Compliant	Compliant	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	NA	Compliant	NA
Results of specialty consultations and referrals[7]	Compliant	Compliant	NA	NA	Compliant
Discharge summaries from ED and hospitalizations	NA	Compliant	NA	NA	Compliant
Special needs treatment plan, where applicable	NA	Compliant	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Partial com	Partial compliance	Partial compliance	Partial compliance	Partial compliance
Current Problem List[3]	Compliant	Compliant	Partial compliance	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	NA	Partial compliance	Partial compliance	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	NA	Compliant	Compliant
Flowsheets	NA	Compliant	Compliant	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	NA	Compliant	Compliant
Results of specialty consultations and referrals[7]	NA	Compliant	NA	NA	Compliant
Discharge summaries from ED and hospitalizations	Compliant	NA	NA	Compliant	NA
Special needs treatment plan, where applicable	Compliant	NA	Compliant	NA	Compliant
Immunization records, where applicable	NA	NA	NA	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☑ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	NA	Compliant	Compliant
Flowsheets	NA	Compliant	Compliant	NA	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	Compliant	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	Compliant	Compliant
Special needs treatment plan, where applicable	NA	Compliant	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	Compliant	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 3/10/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? not av
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 50%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		0	NA	NA
4		1	NA	NA
5		1	NA	NA
6		0	NA	NA
7		2	NA	NA
8		3	NA	NA
9		4	YES	YES
10		6	YES	YES
	Total		2 /2 100%	2 /2 100%

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000804

MEDICATION ADMINISTRATION PRACTICES

DATE 2/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? not av
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 40%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A # (b)(6); (b)(7)(C)	1	2	3
1		3	NA	NA
2		0	NA	NA
3		1	NA	NA
4		0	NA	NA
5		4	YES	YES
6		4	YES	YES
7		11	YES	YES
8		2	NA	NA
9		3	NA	NA
10		14	YES	YES
	Total		4 /4 100%	4 /4 100%

Reviewed February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		NA
3		YES
4		YES
5		YES
6		YES
7		YES
8		NA
9		YES
10		YES
	Total	8 / 8 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item #	Measure
1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A # (b)(6); (b)(7)(C)	1
1		YES
2		NA
3		NA
4		NA
5		YES
6		YES
7		NA
8		NA
9		YES
10		YES
	Total	5 / 5 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	NA
8		YES	NA
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	8 / 8 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000808

MENTAL HEALTH TREATMENT PLANNING

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000809

INTAKE EVALUATION: PREGNANT WOMEN

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1		NA	NA	NA	NA	NO	NO
2		NA	NA	NA	NA	NO	NO
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	0 /0 NaN %	0 /0 NaN %	0 /0 NaN %	0 /0 NaN %	0 /0 NaN %	0 /0 NaN %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

INTAKE EVALUATION: PREGNANT WOMEN

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA	YES	YES
2		YES	YES	YES	NA	YES	YES
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	2 /2 100 %	2 /2 100 %	2 /2 100 %	0 /0 NaN %	2 /2 100 %	2 /2 100 %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
09/18/2017	03/06/2017	Imperial Regional Detention Facility

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	San Diego AOR

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☒ Other: PBNDS 2016 revisions

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
694	644	50	2	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
7	2	1	0	3	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 618- (b)(6); (b)(7)(C)	Phone Number: +1 (760) 618- (b)(6); (b)(7)(C)
Address: 1572 Gateway Road Calexico, CA 92231	Address: 1572 Gateway Road Calexico, CA 92231

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No new medical care deficiencies found during this site visit.

Continued deficiency finding:
PBNDS 2011: 4.3 Medical Care, B. Designation of Authority; Health care personnel perform duties within their scope of practice for which they are credentialed by training, licensure, certification, job description, and/or written standing or direct orders by personnel authorized by law to give such orders.

-Two of ten (20%) charts had upon intake, nurses continuing previously prescribed medications from other facilities without receiving orders from a mid-level provider or physician at the facility to continue the medication. The detainee's medications that they arrive to the facility with are placed on pill line (except for inhalers). Only medications that are labeled appropriately in separate bottles/blister packs are continued until re-ordered by the facility provider. The provider co-signs the order usually within 24 hours. (Outside RN scope of practice)

Resolved findings:
-20 of 20 (100%) had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or have a chronic illness.

-OHU medical housing had a separate section in the medical chart in ten out of ten (100%) charts reviewed.

Previous Site Visit March 2017:

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-Upon intake, nurses continue prescribed medications without first consulting or getting approval from a mid-level or MD to continue the medication. (Outside RN scope of practice)

19 of 20 (95%) had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or have a chronic illness. (PBNDS 2011)

-OHU medical housing had a separate section designated in the medical chart in nine out of ten (90%) charts reviewed. (PBNDS 2011)

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
60	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No current deficiencies noted.

Previous Site Visit March 2017:
No deficiencies.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Three hunger strikes charts were available to review. All medical staff are current on hunger strike training. No deficiencies were noted.

At time of review, the clinical director will not compose a declaration for a force feed court order and will not provide orders for an involuntary force feed within the IRDF facility.

Previous Site Visit March 2017:
No hunger strike charts available to review.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	44

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Reviewed 10 medical records. Detainees are placed in a secure one-to-one observation status in a fully modified cell in the observation housing unit (OHU) when a suicidal ideation or attempt is made. Detainees are followed up by a qualified behavioral health provider at least every 24 hours while on suicide watch.

The facility has one designated suicide watch room, which has been modified to be without structures that could aid in self-harm. If a second detainee requires a 1:1 suicide watch, they are sent to Alvarado Parkway Institute, an inpatient psychiatric hospital, when appropriate.

Previous Site Visit March 2017:
No deficiencies noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Previous Site Visit March 2017:
No deficiencies noted.

Other Observations

IHSC FMC Site Visit September 18-22, 2017. The facility transitioned to PBNDS 2016 revisions on June 1, 2017.

47 total charts reviewed.

Facility Data:
Imperial Regional Detention facility is a dedicated IGSA with MTC as the contractor for both security and medical personnel.
The average length of stay is 88 days.

In the observation housing unit (OHU) located in the medical department there are six negative pressure rooms, one designated suicide watch room, and seven non-negative pressure rooms. There is a desk within sound of the OHU rooms where a security staff member is posted. The officer posted there conducts visual rounds no less than every 30 minutes, and more frequently, as the provider orders.

Staffing-

(b)(7)(E)

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(b)(7)(E)

Deficiencies for Areas Evaluated

Deficiencies are resolved when findings are 100%.

Two of ten (20%) charts had upon intake, nurses continue previously prescribed medications from other facilities without first consulting and getting approval from a mid-level or MD to continue the medication. (Outside RN scope of practice)

Audit Tool findings (not deficiencies):

In one out of five charts with a diagnosis of diabetes reviewed, a blood sugar was not measured at the intake screening though the diagnosis of diabetes was noted. (Quality of Care)

A documented time urgency is not consistently included on the order for specialty care or diagnostic services. (Quality of care)

In three of ten charts reviewed for laboratory testing, there was not documentation showing the patient was advised of their laboratory results. (Quality of care)

There is no annual dental refresher training for nursing staff for RN physical exams and dental sick call evaluations. (Quality of care)

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Suicide Screening

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts reviewed had the suicidal patient evaluated by a mental health professional within 24 hours of identification or immediately if the situation was emergent, and the patient was evaluated daily while on suicide watch by a qualified mental health professional. Constant 1:1 monitoring was practiced while the patient was on suicide watch in all ten charts reviewed. Zero of ten (0%) charts had evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch. Documentation that the checks were documented consistently were not available in the medical charts to review. The constant 1:1 documentation of checks are stored in the custody files and were not available to be reviewed at time of the site visit.

Additional Comments:
In the previous three months, 15 patients were placed on suicide watch at the facility and four patients were sent to Alvarado Parkway Institute (API) inpatient psychiatric hospital for suicidality.

The facility uses an acceptable suicide risk management screening tool during the intake screening that asks for history of suicide attempts and current suicidal ideation. Training logs indicate that all screeners and staff in direct contact with detainees are trained to assess suicide risk.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Health Assessment

20 charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. 20 of 20 (100%) charts had the initial screen completed within 12 hours of booking and had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or chronic illness was noted. 18 of 18 (100%) charts had a chest x-ray ordered and read. Three of three (100%) charts of detainees who screened positive for mental illness or suicide risk were referred for evaluation. 16 of 16 (100%) charts had timely follow-up for significant findings of acute and chronic conditions.

Additional Comments:
In 20 charts reviewed, none were noted to have PPDs placed during intake as chest x-rays are performed. Two charts had a negative chest x-ray result within six months from a previous housing facility.

Previous Site Visit March 2017:
Findings met audit tool criteria except one chart reviewed with a hypertension diagnosis did not have a complete health examination within 48 hours.

Urgent Care (Sick Call)

Three charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Three of three (100%) charts had timely and appropriate evaluation by nursing staff, care was delivered within the scope of the nurse's license, vital signs were documented, a nursing referral to a MD/PA/NP/DMD submitted within 24 hours where appropriate, and if referred, an MD/PA/NP/DMD assessment and plan documented.

Additional Comments:
Only three charts were available to review that contained an urgent care visit for a potentially serious complaint that occurred one to three weeks prior to review.

All telephone orders documented by the RN were co-signed by the ordering provider.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

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Four charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Four of four (100%) charts had an outbound progress note, discharge documentation from the hospital or emergency room in the chart, had an inbound assessment, and had assessments that reflect hospital findings and concurrence with hospital recommendations. Zero of four (0%) charts had evidence that earlier intervention might have prevented deterioration to the point of need for hospital care.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria. No charts reviewed had evidence that earlier intervention would have prevented the need for emergency care.

Medication Administration Practices

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Four of four (100%) charts had documentation that the prescribing clinician was notified of consecutive refusals and there was an appropriate response from the clinician.

Additional Comments:

The facility uses MTC medical policy "Pharmaceutical Management" No. 904E.128FNI which states "Detainees who are on direct observation therapy and refuse medication three consecutive times will be placed on chart review for the medical provider. Upon review the medical provider will determine if medication will be continued, detainee will be seen or medication will be discontinued. Medications for the following conditions will be placed on for review after only one refusal, TB and HIV."

All previous months of MARs were filed in the record filing area. Over the counter medications are provided by both the medical department and can be purchased from the commissary. The current and previous month of MARs was not available to review the percentage that have blanks, consecutive refusals, or no shows.

40% of patients are on self-administered medication, also called keep on person (KOP) medication. This percentage dropped from 50% provider ordered KOP medication during the previous review. MTC Corporate has recommended that NSAIDS (non-steroidal anti-inflammatory drugs) are only to be administered via pill line for for a maximum of 10 doses ordered at one time.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria. 50% of patients were on self-administered medication.

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Continuity of Medication

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts had the period of time from completion of intake screening to the ordering of medications [by a provider with medication prescribing privileges] less than 24 hours, and had a less than 24 hour period of time from the order to first dose of medication.

Additional Comments:
Though all findings meet the audit tool criteria, two charts of ten (20%) reviewed had the nurse continuing medications from intake without a IRDF provider order. This is outside the RN scope of practice. No MTC medical policy was available to review that allows this process.

Previous Site Visit March 2017:
Three of ten charts had the Registered Nurse (RN) continuing medication at intake listed on the transfer summary without a MD/NP at IRDF providing a medication order. No IRDF policy was given to the FMC that included a standing order to continue previously prescribed medication at intake without a facility provider order.

Mental Health Screen

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Five of five (100%) charts of detainees with positive screens for mental illness were evaluated by mental health professionals in a timely manner (emergent= immediately, urgent= within 24 hours; routine= within 7 days).

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Medical Recordkeeping Practices

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts were compliant for identifying information including detainee name, ID number, date of birth, and gender. All ten charts were compliant for current problem list, receiving screen and health assessment forms, progress notes, clinician orders for medication signed, MARs placed in the record within 2 weeks of previous month, consents for medical care and treatment, date and time of each encounter, integrated medical, dental, and mental health record, timely filing within 72 hours, and content organized for easy retrieval of outside records, pertinent diagnostics and consultations.

Seven of seven (100%) charts were compliant for labs and diagnostic reports acknowledged and dated. Six of six (100%) charts were compliant for flowsheets. Eight of eight (100%) charts were compliant for signed refusals of care. Four of four (100%) charts were compliant for results of specialty consultations and referrals acknowledged and dated, and discharge summaries from the ED and hospitalizations. Two of two (100%) charts were compliant for a special needs treatment plan. One of one (100%) chart was compliant for a consolidated medical record, records from prior stays incorporated.

Additional Comments:
The facility uses a paper medical record. Med/psych alert stickers and chronic care labels were listed on all outside covers of chronic care charts reviewed. OHU medical housing had a separate section designated in ten out of ten (100%) charts reviewed.

Previous Site Visit March 2017:
OHU medical housing had a separate section in nine out of ten charts reviewed. No loose, unfastened papers were noted in medical charts.

Nine of ten charts had a current problem list including medical and mental health diagnoses and known allergies. One of ten was partially compliant, missing the mental health diagnosis on the problem list. Six of nine charts were partially compliant for MARs placed in the record within two weeks of the previous month.

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Pregnant Women

Two charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Two of two (100%) charts had a pregnancy test performed on females aged 18-54 during intake screening and prior to an x-ray or before initiation of medications, had an OB/GYN consult ordered within 7 days of pregnancy confirmation, had the patient screened for HIV, STI, and viral hepatitis, and had prenatal vitamins prescribed.

Additional Comments:
Pregnancy tests are performed on all females age 18-65 during intake screening.

Both charts reviewed were housed at IRDF for less than 20 days.

Previous Site Visit March 2017:
No charts were available to review for this area.
Local ICE ERO continues to release any female identified as pregnant during intake.

Dental Care

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts were screened for symptoms during the intake process, the patient was evaluated by a qualified health professional within 48 hours of request, and the dental clinical notes describe findings, diagnosis, and treatment plans. Seven of seven (100%) charts had the patient scheduled for follow-up treatment as recommended.

Additional Comments:
Dental scheduled appointments are now also written in the narrative section of the medical chart. Previously the appointments were only entered into the Offender Data System (ODS) computerized database.

A RN evaluates dental sick calls through a face-to face encounter within 24 hours. The RN then places a chart review for the dentist to review the sick call assessment. The dentist schedules the patient to be seen within 5-14 days based on the acuity of the complaint in the RN assessment.

Four of four charts had an annual dental exam and cleaning documented in the medical chart for detainees in custody over one year.

The dentist provides dental assessment training only upon new RN hire. Nursing staff who perform dental sick call triage and the dental assessment of the physical exam do not receive annual refresher training.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria. Annual dental examination refresher training for RN PE and sick call evaluations is not being provided to nursing staff. Dental scheduled appointments are entered into ODS, but are not written in the narrative section of the medical chart. Only when an appointment needs to be rescheduled does a notation of the scheduled appointment appear in the medical chart.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts reviewed had blood drawn or test done within one business day of ordered date, report was back within 24 hours for acute labs or within 7 days for routine labs, had clinical acknowledgment and an appropriate clinical response. Seven of ten (70%) charts had documentation the patient was advised of laboratory results.

Additional Comments:
The director of nursing checks the lab log weekly.

For all acute or urgently needed lab work, detainees are transported to El Centro Regional Medical Center within 24 hours for lab draw. IRDF's contracted laboratory provider, Garcia labs, does not process stat labs. Garcia labs consistently provides routine lab results to the facility in a timely manner.

Previous Site Visit March 2017:
All findings met audit tool criteria except one of ten charts had blood drawn or test done within one business day of the ordered lab.

Diagnostic Services and Specialty Care Access

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts had the appointment accomplished within 45 days of the order or within the ordered timeframe, and the facility clinician acknowledged the specialist's report in the medical record within 7 days of the date the service was performed. Three of ten (30%) charts had a documented time urgency included on the order for specialty care or diagnostic services.

Additional Comments:
All of the specialty care referrals were completed within 30 days. Detainees are referred to appropriate specialists in a timely manner through the MedPAR system.

Previous Site Visit March 2017:
Zero charts had a documented time urgency for the specialty care or diagnostic service ordered. Eight of ten had the facility clinician acknowledge the specialist's report in the medical record within seven days of the date of service.

Mental Health Treatment Planning

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts had a clinical assessment, treatment, and follow-up plan documented and had treatment plans updated at a minimum of every 90 days.

Additional Comments:
Treatment plans were updated every 21-45 days dependent upon patient acuity.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Treatment of Disability

Two charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Two of two (100%) charts had the patient disability prominently noted in the file along with any needed accommodations, had the patient assessed for assistance with activities of daily living (ADL) upon identification of disability, and had appropriate accommodation orders entered. ADL assistance was not needed by the patient in either case.

In one chart reviewed the disability was right foot drop. Orders for orthotics for gait and balance were entered. A lower bunk/low tier bed and the use of a cane were also entered.

In another chart reviewed the disability was hearing loss. A hearing aid with extra batteries were given to the patient.

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Additional Comments:
The facility maintains a current list of all patients with disabilities.

Previous Site Visit March 2017:
No cases of disability available to review.

Complaints and Grievances

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. There were ten medical grievances from June 2017 through August 2017. The facility's grievances do not reveal any possible barriers to care or repetitive concerns that could affect clinical care. All grievances were addressed within five working days of receipt.

One grievance was due to availability of care.
One grievance was due to denial or refusal of specific request.
Three grievances were due to a delay in care. All three were related to dental complaints. A RN evaluates the patient in a face-to-face encounter within 24 hours. The dentist reviews the RN sick call assessment and schedules an appointment within 14 days based on the dental complaint and corresponding RN assessment.

Five grievances were for "other" complaints. One such grievance was a complaint that the patient was not receiving a cure for his issue and only received medication that relieved his symptoms. One grievance was a request to obtain shoes and medication from his personal property. One grievance stated the patient had not seen the dentist, but the patient was seen prior to the grievance response. Another grievance was a request for a second medical opinion. Another grievance was a patient accusation that a security guard was given confidential information about his medical condition. This accusation was found to not be true.

Additional Comments:
All ten grievances were informal grievances and the detainees were satisfied with the response provided by the medical department.

Previous Site Visit March 2017:
There were 13 total medical grievances in the last three months prior to review. One was a formal grievance, while 12 were informal. All 13 grievances were addressed within five business days.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Five charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Five of five (100%) charts had the patient seen for chronic care by a NP/MD within 14 days of illness identification and had aspirin prescribed as clinically indicated. Four of four (100%) charts had a baseline HgbA1c performed within 30 days of intake or within the last 3 months, had lipids measured within one year, was followed at least every 90 days with appropriate vital signs, and had a degree of control documented. Three of three (100%) charts had a strategy to attain diabetes control documented if HgbA1C was above goal. Four of five (80%) charts had the blood sugar measured and recorded on intake.

In one chart reviewed, a blood sugar was not taken at the intake screening though the diagnosis of diabetes was noted.

Additional Comments:
The clinical director follows the American Diabetes Association and Bureau of Prison Diabetes clinical practice guidelines.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Human Immunodeficiency Virus (HIV)

Four charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Four of four (100%) charts had a CD4+ and viral load completed within 14 days of arrival or within the last three months, patient was seen by an ID specialist within 30 days of HIV identification, had antiretroviral treatment considered and documented, patient was seen by a mid-level provider or physician for chronic care at least every 90 days, and had a chest x-ray completed within 72 hours of problem identification if not already done.

HIV status was identified by recent laboratory results for one chart reviewed, by medical records for one chart reviewed, and by patient interview for two charts reviewed.

Additional Comments:
The clinical director follows Bureau of Prison HIV clinical practice guidelines.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Hypertension

Four charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Four of four (100%) charts had a blood pressure reading noted at intake, was seen by a MD/NP within 14 days of illness identification, had a treatment plan initiated if the blood pressure was >140 systolic or >90 diastolic, and had a chronic disease guideline including baseline laboratory testing followed.

Additional Comments:
The clinical director follows the Bureau of Prison Hypertension clinical guidelines and the American Academy of Family Physicians clinical practice guidelines.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Asthma

Three charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Three of three (100%) charts were seen in the chronic care clinic by a mid-level provider or physician within 14 days of illness identification, had a peak flow completed at the initial physical exam, had a peak flow completed at the chronic care appointment or within the last three months, and had a chronic disease guideline followed which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

Additional Comments:

AMERICAN OVERSIGHT

The clinical director follows the American Academy of Family Physicians asthma clinical practice guidelines and the Bureau of Prison Asthma guidelines.

Previous Site Visit March 2017:
All findings met 100% audit tool criteria.

Seizure Disorder

Two charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Two of two (100%) charts had an appropriate neurological history completed at the initial physical exam, were seen in the chronic care clinic by a NP/MD within 14 days of illness identification, had serum drug levels performed and acknowledged every 3 months until stable, and then every 6 months when indicated, had a treatment plan, and had orders for a bottom bunk.

Additional Comments:
The clinical director uses the American Academy of Family Physicians guidelines to manage seizures.

Previous Site Visit March 2017:
The one chart available to review met audit tool criteria except did not have orders for a bottom bunk.

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

A closeout meeting was conducted with the Health Services Administrator.

A summary of site visit deficiencies was emailed to the FOD, DFOD over detention, AFOD of IRDF, SDDO/AOIC, and CORs on 10/2/2017.

Additional Comments

On 10/3/2017, the CORs asked MTC for clarification on if MTC medical staff will conduct a force feed, if necessary, after a Federal court order is obtained by ICE. A response from MTC is pending as of 10/9/2017.

AMERICAN OVERSIGHT

End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809- (b)(6); (b)(7)(C)	Date Prepared: 10/06/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 10/20/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 10/24/2017

Recommendations:

(b)(5)

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 10

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	N/A	NO
2		YES	YES	Constant (1:1)	N/A	NO
3		YES	YES	Constant (1:1)	N/A	NO
4		YES	YES	Constant (1:1)	N/A	NO
5		YES	YES	Constant (1:1)	N/A	NO
6		YES	YES	Constant (1:1)	N/A	NO
7		YES	YES	Constant (1:1)	N/A	NO
8		YES	YES	Constant (1:1)	N/A	NO
9		YES	YES	Constant (1:1)	N/A	NO
10		YES	YES	Constant (1:1)	N/A	NO
	Total	10 / 10 100 %	10 / 10 100 %		0 / 0 NaN %	0 / 10 0 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 19 (15 1:1, 4 API)

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	N/A	NO
2		YES	YES	Constant (1:1)	N/A	NO
3		YES	YES	Constant (1:1)	N/A	NO
4		YES	YES	Constant (1:1)	N/A	NO
5		YES	YES	Constant (1:1)	N/A	NO
6		YES	YES	Constant (1:1)	N/A	NO
7		YES	YES	Constant (1:1)	N/A	NO
8		YES	YES	Constant (1:1)	N/A	NO
9		YES	YES	Constant (1:1)	N/A	NO
10		YES	YES	Constant (1:1)	N/A	NO
	Total	10 / 10 100 %	10 / 10 100 %		0 / 0 NaN %	0 / 10 0 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED: Imperial Regional Detention Facility

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes

Item # Measure

1 Is the disability prominently noted in the file, along with any needed accommodations?
2 Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3 Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4 Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	no charts available	YES	YES	NA	NA
2	for review	YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	0 / 0 NaN %	0 / 0 NaN %	0 / 0 NaN %	0 / 0 NaN %

KEY: NA = not applicable

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 9/19/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Imperial Regional Detention Facility

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes.

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %	0 / 0 NaN %

KEY: NA = not applicable

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Difficulty breathing	YES	YES	YES	YES	YES
2		Chest pain	YES	YES	YES	YES	YES
3		Chest pain/SOB	YES	YES	YES	YES	YES
4		Rash to neck	YES	YES	YES	YES	YES
5		Rash to face	YES	YES	YES	YES	YES
6		Palpitations	YES	YES	YES	YES	YES
7		Chest pain/Hx of HIV	YES	YES	YES	YES	YES
8		Calcaneal fracture	YES	YES	YES	YES	YES
9			NA	NA	NA	NA	NA
10			NA	NA	NA	NA	NA
		Total	8 /8 100 %	8 /8 100 %	8 /8 100 %	8 /8 100 %	8 /8 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000830

URGENT CARE (SICK CALL)

DATE 9/20/2017 REVIEWE (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	chest pain	YES	YES	YES	YES	YES
2		chest pain	YES	YES	YES	YES	YES
3		inflammation to penis and testicles	YES	YES	YES	YES	YES
4			NA	NA	NA	NA	NA
5			NA	NA	NA	NA	NA
6			NA	NA	NA	NA	NA
7			NA	NA	NA	NA	NA
8			NA	NA	NA	NA	NA
9			NA	NA	NA	NA	NA
10			NA	NA	NA	NA	NA
		Total	3 /3 100 %	3 /3 100 %	3 /3 100 %	3 /3 100 %	3 /3 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

Facility Information				
Facility Name:	Imperial Regional Detention Facility			
AOR:	SND			
Address:	1572 Gateway Road			
City:	Calexico		**County:**	Imperial
State:	CA	**Zip:**	92231	
Inspection Information				
Start Date:	5/21/2018			
End Date:	5/25/2018			
Organization:		IHSC		
# Detainees at Time of Visit:		726		
Total Facility Population at Time of Visit:		726		
Facility Capacity:		782		
Notes:	Imperial Regional Detention Facility is an ICE dedicated IGSA.			
Reviewer Information				
Lead Reviewer Name:	(b)(6); (b)(7)(C)		**Date Signed:**	6/10/2018
Signature:	Invalid signature X (b)(6); (b)(7)(C) SND FMC IHSC Signed by: SAVION.REBECCA.MELODY.1407682471			

HQ Use Only:

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	1	*Total Number
CM	Continuity of Medications	95%	
DC	Dental Care	100%	
DM	Diabetes	100%	
DSA	Diagnostic Services and Specialty Care Access	83%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	97%	
HTM	Hypertension	100%	
LT	Laboratory Testing	98%	
MR	Medical Recordkeeping	74%	
MAR	Medication Administration Records	95%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Medical Secretary						
Other 2						
TOTAL						

AMERICAN OVERSIGHT

INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTM	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:	4							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/22/2018			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		Bureau of Prisons Clinical Practice Guidelines- Asthma 2013					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Totals:	4	4	4	4	4			
Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	N/A - NLOS	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	N/A - NLOS	Yes	Yes			
4		Yes	Yes	Yes	Yes			
5		Select	Select	Select	Select			
6		Select	Select	Select	Select			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:	8	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Type Text Here	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/21/2018

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	Bureau of Prisons Clinical Guidelines- Diabetes 2017, American Diabeties Association
	Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?	
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)	
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?	
cDM-4	Were lipids measured within one year?	
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?	
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.	
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?	
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?	

Totals:	8	8	8	8	8	8	8	8	8
Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A - NLOS
3		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes	N/A - LOS	Yes	N/A - NLOS
5		Yes	Yes	Yes	N/A - LOS	Yes	Yes	Yes	N/A - NLOS
6		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
7	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	Yes	N/A - LOS	N/A - LOS	
8		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
9		Select	Select	Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:	7						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	Type Text Here						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/22/2018			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	Bureau of Prisons Clinical Guidelines- Management of HIV 2016					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Totals:	7		7	6	7	7	7
Compliance:	97%		100%	86%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**
1	(b)(6); (b)(7)(C)	Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
2	(b)(6); (b)(7)(C)	Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
3		Patient Interview	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
4		Patient Interview	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
5		Patient Interview	Yes	No	Yes	Yes	Yes	
6		Patient Interview	Yes	Yes	Yes	Yes	Yes	
7		Patient Interview	Yes	Yes	Yes	Yes	Yes	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:	10							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018			
Facility (f)								
fHTM-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y			
fHTM-1b:	If yes, what is the guideline?		Bureau of Prisons Clinical Guidelines- Hypertension 2015					
Clinical (c)								
cHTM-1	Was a blood pressure reading noted at intake?							
cHTM-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTM-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTM-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Totals:	10	10	10	10	10			
Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cHTM-1**	**cHTM-2**	**cHTM-3**	**cHTM-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	Yes			
2		Y	Yes	N/A - NLOS	Yes			
3		Y	Yes	N/A - NLOS	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	N/A - NLOS	Yes			
8		Y	Yes	N/A - NLOS	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	N/A - NLOS	Yes			

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:	4					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	American Academy of Family Physicians guidelines				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Totals:	4	4	4	4	4	4
Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS									
Number of Files Reviewed for Patients Meeting this Criteria:		10							
Purpose:	To assess timeliness of medication, as ordered.								
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).								
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.								
Guidelines:									
Remarks:	Imperial Regional Detention Center uses Diamond Pharmacy to fill their prescription orders. Diamond Pharmacy does not deliver medications on the weekends.								
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018			
Clinical (c)									
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?								
cCM-2	Period of time from order to first dose less than 24 hours?								
Totals:	10	10	9						
Compliance:	95%	100%	90%						
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**						
1	(b)(6); (b)(7)(C)	Yes	No						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:	10							
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	Per the FMC September 2017 Site Visit Uniform Corrective Action Plan, a quality of care finding was noted. The dentist provides dental assessment training upon new RN hire. Nursing staff who perform dental sick call triage and the dental assessment of the physical exam do not receive annual refresher training. The facility has stated they will provide additional dental education as needed for RNs, however they do not wish to provide annual dental refresher training.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/22/2018			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Totals:	10	10	10	10	10			
Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	N/A - NLOS			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:	Detainees are referred to appropriate specialists in a timely manner through the MedPAR system.					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/21/2018		

Clinical (c)	
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

Totals:	10		5	10	9	9
Compliance:	83%		50%	100%	90%	90%

Patient(s)	A# (numbers only)	Clinic	cDSA-1	cDSA-2	cDSA-3	cDSA-4
1	(b)(6); (b)(7)(C)	Other	No	Yes	N/A - NLOS	Yes
2		OB/Gyn	Yes	Yes	N/A - NLOS	No
3		OB/Gyn	Yes	Yes	N/A - NLOS	Yes
4		Opthalmology	Yes	Yes	No	Yes
5		OB/Gyn	No	Yes	N/A - NLOS	Yes
6		OB/Gyn	No	N/A - LOS	N/A - LOS	N/A - LOS
7		General Surgery	Yes	N/A - LOS	N/A - LOS	N/A - LOS
8		Other	Yes	Yes	N/A - NLOS	Yes
9		Gastroenterology	No	Yes	N/A - NLOS	N/A - NLOS
10		Infectious Disease	No	Yes	N/A - NLOS	Yes

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:	5							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	5/21/2018		
			Clinical (c)					
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Totals:	5		5	5	5	5	5	
Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Chest pain	Yes	No	Yes	Yes	Yes	
2		Pregnant detainee, pelvic pain and vaginal bleeding	Yes	No	Yes	Yes	Yes	
3		ETOH withdrawal	Yes	No	Yes	Yes	Yes	
4		Head injury with laceration needing staples (fall from top bunk)	Yes	No	Yes	Yes	Yes	
5		Prolonged fever with tachycardia, ER dx of Influenza B	Yes	No	Yes	Yes	Yes	
6			Select	Select	Select	Select	Select	
7			Select	Select	Select	Select	Select	
8			Select	Select	Select	Select	Select	
9			Select	Select	Select	Select	Select	
10			Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:	2						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	The Director of Nursing serves as the medical grievance officer.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/23/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			2			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			2			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	1	1	1	0	0	0	0
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	1	Select	Select	Select	Select	Select
2		Select	1	Select	Select	Select	Select
3		Select	Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	All new arrivals without chest x-ray confirmed TB clearance receive a chest x-ray, except for pregnant detainees who recieve a PPD. Physical examatinations are completed on the same day as the intake screening by a Registered Nurse. The Clinical Director reviews and signs off on all physical examinations.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018	

Clinical (c)	
cHA-1	Initial screen complete within 12 hours of booking?
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.

Totals:	20	20	20	20	20	20
Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	Yes
2		Yes	Yes	N/A	Yes	Yes
3		Yes	Yes	N/A	Yes	Yes
4		Yes	Yes	N/A	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	N/A	N/A - NLOS	Yes
7		Yes	Yes	N/A	N/A - NLOS	Yes
8		Yes	Yes	N/A	Yes	Yes
9		Yes	Yes	N/A	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		Yes	Yes	N/A	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	Yes	N/A - NLOS	Yes
16		Yes	Yes	N/A	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess timeliness, continuity, and coordination of care.					
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.					
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.					
Guidelines:						
Remarks:	The Director of Nursing (DON) or Health Services Administrator (HSA) checks the lab log weekly. For all acute or urgently needed lab work, detainees are transported to El Centro Regional Medical Center within 24 hours for lab draw. IRDF's contracted laboratory provider, Garcia labs, does not process stat labs. Garcia labs consistently provides routine lab results to the facility in a timely manner.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018	
Clinical (c)						
cLT-1	Was blood drawn or test done within 1 business day of ordered date?					
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?					
cLT-3	Was there clinical acknowledgment?					
cLT-4	Was there an appropriate clinical response?					
cLT-5	Was patient advised of laboratory results?					
Totals:	10	10	10	10	10	9
Compliance:	98%	100%	100%	100%	100%	90%

Patient(s)	A# (numbers only)	cLT-1	cLT-2	cLT-3	cLT-4	cLT-5
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	No
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:	The facility uses MTC medical policy "Pharmaceutical Management" No. 904E.128FNI which states "Detainees who are on direct observation therapy and refuse medication three consecutive times will be placed on chart review for the medical provider. Upon review the medical provider will determine if medication will be continued, detainee will be seen or medication will be discontinued. Medications for the following conditions will be placed on for review after only one refusal, TB and HIV."								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/23/2018				
Facility (f)									
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y				
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				4				
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0				
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				47				
fMAR-5:	OTCs provided by medical, commissary or both?				Both				
Clinical (c)									
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?								
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?								
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)								
Totals:	10	23	9	10					
Compliance:	95%		90%	100%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS					
2		0	N/A - NLOS	N/A - NLOS					
3		0	N/A - NLOS	N/A - NLOS					
4		0	N/A - NLOS	N/A - NLOS					
5		0	N/A - NLOS	N/A - NLOS					
6		4	N/A - NLOS	N/A - NLOS					
7		7	Yes	Yes					
8		2	N/A - NLOS	N/A - NLOS					
9		10	No	Yes					
10		0	N/A - NLOS	N/A - NLOS					

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(b)(6);
(b)(7)(C)

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	Type Text Here
Reviewer:	**Date Reviewed:** 5/21/2018

	Facility (f)	
fMR-1:	Type of Medical Records?	Paper
fMR-2:	Name of Electronic Health Record?	n/a

Totals:	10	10	10	10	10	10	10	10	9	10	6	5	4	9	1	10	10	10	2	10	0	0
Compliance:	74%	100%	100%	100%	100%	100%	100%	100%	90%	100%	60%	50%	40%	90%	10%	100%	100%	100%	20%	100%	0%	0%

Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

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MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:	10								
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	Type Text Here								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018				
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Totals:	10	10							
Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		N/A - NLOS							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	The psychiatrist sees patients every 14-45 days depending on patient acuity if on pyschotropic medications.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2018				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Totals:	10	10	10						
Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:	4					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	The pregnant detainees in the four charts reviewed were housed at IRDF between 19 and 28 days.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/23/2018	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?	Yes				
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					

Totals:	4	4	4	4	4	4
Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A - LOS	Yes	Yes
4		Yes	Yes	N/A - LOS	Yes	Yes
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	MTC security staff conduct 1:1 constant observation for detainees placed on suicide watch. Documentation of the constant observation is maintained in the detention files; these files were not readily available to be reviewed. Detention staff did provide one detention file to review that was placed on suicide watch. Nine patients have been placed on suicide watch or hospitalized for suicidality within the last three months, with two patients being placed on suicide watch on multiple occassions.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/22/2018	
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?				12	
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?				Y	
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?				Y	
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Totals:	10		10	10	10	10
Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	N/A - NLOS	Yes	Yes	No
2		Constant (1:1)	N/A - NLOS	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	N/A - NLOS	Yes	Yes	No
5		Constant (1:1)	N/A - NLOS	Yes	Yes	No
6		Constant (1:1)	N/A - NLOS	Yes	Yes	No
7		Constant (1:1)	N/A - NLOS	Yes	Yes	No
8		Constant (1:1)	N/A - NLOS	Yes	Yes	No
9		Constant (1:1)	N/A - NLOS	Yes	Yes	No
10		Constant (1:1)	N/A - NLOS	Yes	Yes	No

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TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:	4					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	Any detainee who arrives to the facility with a disability is immediately evaluated by medical staff. MTC form "Detainee Disability Accomodation Notification" is filled out, followed by a 30 and 90 day re-evaluation as applicable.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/24/2018	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Totals:	4	4	4	4	4	
Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS	
2		Yes	Yes	Yes	N/A - NLOS	
3		Yes	Yes	Yes	N/A - NLOS	
4		Yes	Yes	Yes	N/A - NLOS	
5		Select	Select	Select	Select	
6		Select	Select	Select	Select	
7		Select	Select	Select	Select	
8		Select	Select	Select	Select	
9		Select	Select	Select	Select	
10		Select	Select	Select	Select	

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:	4							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	5/22/2018	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Totals:	4		4	4	4	4	4	
Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1			Select	Select	Select	Select	Select	
2	(b)(6); (b)(7)(C)	Chest Pain	Yes	Yes	Yes	Yes	N/A - NLOS	
3		Chest Pain/ Diminished Lung Sounds	Yes	Yes	Yes	Yes	Yes	
4		Pregnant detainee, pelvic pain and vaginal bleeding	Yes	Yes	Yes	Yes	Yes	
5		Facial abscess	Yes	Yes	Yes	Yes	Yes	
6			Select	Select	Select	Select	Select	
7			Select	Select	Select	Select	Select	
8			Select	Select	Select	Select	Select	
9			Select	Select	Select	Select	Select	
10			Select	Select	Select	Select	Select	

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Imperial Regional Detention Facility			
AOR:*	SND			
Address:	1572 Gateway Road			
City:	Calexico		**County:**	Imperial
State:*	CA	**Zip:**	92231	
Inspection Information				
Start Date:*	7/8/2019			
End Date:*	7/12/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		637		
Total Facility Population at Time of Visit:		637		
Facility Capacity:		782		
Notes:	The Imperial Regional Detention Facility (IRDF) is an ICE dedicated IGSA. IRDF operates under MTC medical and custody staff contractor. There are 704 general population beds, 64 restricted housing unit beds, and 14 medical beds.			
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	8/21/2019
Signature:	10/18/2019 X (b)(6); (b)(7)(C) Signed by: REBECCA M SAVION			

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Signed by: (b)(6); (b)(7)(C)

HQ Use Only: *30* *5/20/2019*

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	19	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	98%	
DM	Diabetes	100%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	100%	
HTN	Hypertension	97%	
LT	Laboratory Testing	94%	
MR	Medical Recordkeeping	98%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX							
*1 FTE = 40 hours / per week							
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**	**Comments**
C.N.A.	(b)(7)(E)						
Dental Assistant							
Dentist							
EMT							
H.S.A.							
LVN/LPN							
MH Counselor							
MRT							
NP/PA							
Nurse Manager							
Paramedic							
Pharmacist							
Pharmacy Tech							
Physician							
Psychiatrist							
Psychologist							
RN							
Social Worker							
X-ray Tech							
Other 1- Secretary							
Other 2							
TOTAL							

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		7						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/10/2019			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?			Federal Bureau of Prisons Clinical Guidance May 2013, reformatted June 2018				
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		7	7	7	7			
Total Met:		7	7	7	7			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	Yes	Yes	Yes			
4		Yes	Yes	Yes	Yes			
5		Yes	Yes	Yes	Yes			
6		Yes	Yes	Yes	Yes			
7		Yes	Yes	Yes	Yes			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	5	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 7/9/2019

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	Federal Bureau of Prisons Clinical Guidance March 2017

Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		5	5	5	5	5	0	5	5
Total Met:		5	5	5	5	5	0	5	5
% Compliance:	100%	100%	100%	100%	100%	100%		100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes

AMERICAN OVERSIGHT

Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6		Select	Select	Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	Previous FMC Site Visit May 2018: In one chart reviewed, the detainee was not seen by an Infectious Disease specialist within 30 days of HIV identification.						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	7/9/2019			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	Federal Bureau of Prisons Clinical Guidance September 2018					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			4	3	4	4	4
Total Met:			4	3	4	4	4
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

AMERICAN OVERSIGHT

~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Recent Lab	Yes	Yes	Yes	Yes	Yes	
2		Patient Interview	Yes	Yes	Yes	Yes	Yes	
3		Recent Lab	Yes	Yes	Yes	Yes	Yes	
4		Patient Interview	Yes	N/A - LOS	Yes	Yes	Yes	
5		Select	Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		8						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:	(b)(6); (b)(7)(C) Arrived on 3/15/2019 and labwork was ordered via Telephone Order (TO) and NP was supposed to evaluate on 3/18/2019. NP did not see patient as scheduled, MD evaluated pt on 4/3/2019. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/8/2019			
Facility (f)								
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y			
fHTN-1b:	If yes, what is the guideline?		Federal Bureau of Prisons Clinical Guidance May 2015					
Clinical (c)								
cHTN-1	Was a blood pressure reading noted at intake?							
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Total Applicable:		8	8	8	8			
Total Met:		8	7	8	8			
% Compliance:	97%	100%	88%	100%	100%			
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	No	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		5				
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/11/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	American Academy of Family Physcians Seizure Guidelines				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		5	5	2	5	5
Total Met:		5	5	2	5	5
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	N/A - LOS	Yes	Yes
5		Yes	Yes	N/A - LOS	Yes	Yes
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:	Previous FMC Site Visit May 2018: In one chart the period of time from the medication order to the first dose was more than 24 hours.		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	7/8/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	10
Total Met:		10	10
% Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

AMERICAN OVERSIGHT

DENTAL CARE						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess compliance with detention standards and continuity of care.					
Source:	Dental sick call list or dental referral log.					
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.					
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.					
Remarks:	(b)(6); (b)(7)(C) Dentist evaluated pt on 3/15/2019 for dental pain and noted tooth #13 needed a filling. No follow up scheduled. RN saw pt for dental sick call on 5/1/2019 and chart reviewed by the dentist. Filling completed on 5/9/2019. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/8/2019	
Clinical (c)						
cDC-1	Was patient screened for symptoms during the intake process?					
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?					
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?					
cDC-4	Was the patient scheduled for follow-up treatment as recommended?					
Total Applicable:		10	10	9	10	
Total Met:		10	10	9	9	
% Compliance:	98%	100%	100%	100%	90%	

Patient(s)	A# (numbers only)	cDC-1	cDC-2	cDC-3	cDC-4
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes
2		Y	Yes	Yes	Yes
3		Y	Yes	Yes	Yes
4		Y	Yes	Yes	Yes
5		Y	Yes	Yes	Yes
6		Y	Yes	N/A - LOS	Yes
7		Y	Yes	Yes	Yes
8		Y	Yes	Yes	No
9		Y	Yes	Yes	Yes
10		Y	Yes	Yes	Yes

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.	
Source:	Referrals log, medical records or MedPars.	
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.	
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.	
Remarks:	Previous FMC Site Visit May 2018: Five of ten charts did not have a documented time urgency on the order. In one chart the pt was not re-evaluated every 30 days and the provider didn't review the study results within seven days.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 7/11/2019

Clinical (c)	
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

Total Applicable:			10	10	4	10
Total Met:			10	10	4	10
% Compliance:	100%		100%	100%	100%	100%

Patient(s)	A# (numbers only)	Clinic	cDSA-1	cDSA-2	cDSA-3	cDSA-4
1	(b)(6); (b)(7)(C)	Cardiology	Yes	Yes	N/A - NLOS	Yes
2		Infectious Disease	Yes	Yes	Yes	Yes
3		Infectious Disease	Yes	Yes	Yes	Yes
4		Infectious Disease	Yes	Yes	Yes	Yes
5		Opthalmology	Yes	Yes	N/A - NLOS	Yes
6		OB/Gyn	Yes	Yes	Yes	Yes
7		Gastroenterology	Yes	Yes	N/A - NLOS	Yes
8		Orthopedics	Yes	Yes	N/A - NLOS	Yes
9		Opthalmology	Yes	Yes	N/A - NLOS	Yes
10		Infectious Disease	Yes	Yes	N/A - NLOS	Yes

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.							
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	7/10/2019	
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			4	4	4	4	4	
Total Met:			4	4	4	4	4	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	High fever, tachycardia, shortness of beath	Yes	No	Yes	Yes	Yes	
2		Lacteration to eye	Yes	No	Yes	Yes	Yes	
3		Severe abdominal pain	Yes	No	Yes	Yes	Yes	
4		Seizure like activity	Yes	No	Yes	Yes	Yes	
5			Select	Select	Select	Select	Select	
6			Select	Select	Select	Select	Select	
7			Select	Select	Select	Select	Select	
8			Select	Select	Select	Select	Select	
9			Select	Select	Select	Select	Select	
10			Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	19						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	(b)(6); (b)(7)(C) Grievances include pt unhappy he was removed from work duty after complaining of unrelieved hand pain. "Other" grievances include requests to know when an off-site or follow up appointment was scheduled. This category also includes grievances submitted instead of a sick call request to be seen by medical staff immediately. Medical staff cannot provide specific date of appointment due to security precautions, but informed patients if an upcoming appointment was scheduled. Previous FMC Site Visit May 2018: Grievances addressed within one business day.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/11/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			26			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			26			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	19	5	4	2	2	1	12
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	0	0	0	0	0	1
2		0	0	0	0	0	1
3		0	0	0	0	0	2
4		0	0	0	0	0	3
5		0	1	0	0	0	0
6		0	0	0	1	0	0
7		0	1	0	0	0	0
8		2	0	0	0	0	0
9		0	0	0	0	1	1
10		1	1	0	1	0	0
11		0	0	0	0	0	1
12		0	0	1	0	0	0
13		1	0	0	0	0	0
14		0	1	0	0	0	0
15		0	0	0	0	0	1
16		0	0	0	0	0	1
17		1	0	0	0	0	0
18		0	0	0	0	0	1
19		0	0	1	0	0	0
20		Select	Select	Select	Select	Select	Select
21		Select	Select	Select	Select	Select	Select
22		Select	Select	Select	Select	Select	Select
23		Select	Select	Select	Select	Select	Select
24		Select	Select	Select	Select	Select	Select
25		Select	Select	Select	Select	Select	Select
26		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	All new arrivals without tuberculosis clearance receive a 1-view chest x-ray. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/9/2019	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	6	12	20
Total Met:		20	20	6	12	20
% Compliance:	100%	100%	100%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	N/A - NLOS	Yes
2		Yes	Yes	N/A	N/A - NLOS	Yes
3		Yes	Yes	N/A	N/A - NLOS	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	N/A	Yes	Yes
7		Yes	Yes	N/A	Yes	Yes
8		Yes	Yes	N/A	N/A - NLOS	Yes
9		Yes	Yes	N/A	N/A - NLOS	Yes
10		Yes	Yes	N/A	N/A - NLOS	Yes
11		Yes	Yes	Yes	Yes	Yes
12		Yes	Yes	N/A	N/A - NLOS	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	Yes	Yes	Yes
15		Yes	Yes	Yes	N/A - NLOS	Yes
16		Yes	Yes	Yes	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	N/A	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	The facility uses LabCorp (b)(6); (b)(7)(C) Labs were ordered on 6/5/19 and drawn on 6/11/19. (b)(6); (b)(7)(C) NP did not go over mumps results; however, detainee was released from cohort appropriately Results of labs not reviewed with patient. Previous FMC Site Visit May 2018: In one chart the patient was not advised of his lab results.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/8/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		9	10	10	10	8	
% Compliance:	94%	90%	100%	100%	100%	80%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	No	
2		Yes	Yes	Yes	Yes	Yes	
3		No	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	No	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:	Previous FMC Site Visit May 2018: In one chart the notification of consecutive refusals was made in the ODS computer system rather than within the medical paper chart.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/10/2019				

Facility (f)		
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?	Y
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?	10
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?	0
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.	46
fMAR-5:	OTCs provided by medical, commissary or both?	Both

Clinical (c)	
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

Total Applicable:			2	2
Total Met:			2	2
% Compliance:	100%		100%	100%

Patient(s)	A# (numbers only)	cMAR-1	cMAR-2	cMAR-3
1	(b)(6); (b)(7)(C)	1	N/A - NLOS	N/A - NLOS
2		0	N/A - NLOS	N/A - NLOS
3		0	N/A - NLOS	N/A - NLOS
4		0	N/A - NLOS	N/A - NLOS
5		5	Yes	Yes
6		0	N/A - NLOS	N/A - NLOS
7		0	N/A - NLOS	N/A - NLOS
8		0	N/A - NLOS	N/A - NLOS
9		4	N/A - NLOS	N/A - NLOS
10		7	Yes	Yes

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(b)(6);
(b)(7)(C)

(b)(6);
(b)(7)(C)

(b)(6);
(b)(7)(C)

MEDICAL RECORD KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	Facility will begin to transition to an electronic health record called Sapphire within the next three-six months. MH diagnosis of rule out adjustment disorder not on problem list [redacted] prior suicide watches not listed on problem list. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.
Reviewer:	**Date Reviewed:** 7/8/2019

	Facility (f)	
fMR-1:	Type of Medical Records?	Paper
fMR-2:	Name of Electronic Health Record?	Pending implmentation of Sapphire electronic health record

Total Applicable:		10	10	10	10	10	8	10	3	10	5	6	0	8	3	10	9	10	0	10	0	0	
Total Met:		10	7	10	10	10	8	10	3	10	5	6	0	8	3	10	9	10	0	10	0	0	
% Compliance:	98%	100%	70%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%		100%			
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
4		Compliant	Partial Compliance	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
6		Compliant	Partial Compliance	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	
10		Compliant	Partial Compliance	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	

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MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	7/9/2019					
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/9/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	6						
Total Met:		10	6						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	N/A - LOS						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	N/A - LOS						
6		Yes	N/A - LOS						
7		Yes	Yes						
8		Yes	N/A - NLOS						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		3				
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/11/2019	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Total Applicable:		3	3	0	3	3
Total Met:		3	3	0	3	3
% Compliance:	100%	100%	100%		100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Yes	Yes	N/A - LOS	Yes	Yes
3		Yes	Yes	N/A - LOS	Yes	Yes
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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SUICIDE SCREENING		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4	

Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32
Remarks:	Documentation of the 1:1 observations conducted by security staff are manintained in the patient detention files and were not available for FMC review. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 7/10/2019

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	4
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			0	4	4	4
Total Met:			0	4	4	4
% Compliance:	100%			100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	N/A - NLOS	Yes	Yes	No
2		Constant (1:1)	N/A - NLOS	Yes	Yes	No
3		Constant (1:1)	N/A - NLOS	Yes	Yes	No
4		Constant (1:1)	N/A - NLOS	Yes	Yes	No
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		5					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	The IRDF detainee disability accomodation workgroup meets and provides a written notification within five working days after the initial request or referral for accomodation per MTC Medical policy Serial No 904E.105.1FNI. A 30 day re-assessment occurs and then continuous 90 day re-assessments occur while housed at IRDF. The Director of Nursing (DON) maintains a tracking log of when the re-assessment is due to occur. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.						
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	7/11/2019		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		5	5	5	0		
Total Met:		5	5	5	0		
% Compliance:	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS		
2		Yes	Yes	Yes	N/A - NLOS		
3		Yes	Yes	Yes	N/A - NLOS		
4		Yes	Yes	Yes	N/A - NLOS		
5		Yes	Yes	Yes	N/A - NLOS		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	5							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	Detainees can electronically submit sick call requests 24/7 via a hand-held tablet system. Detainees are educated on tablet use upon arrival by custody staff. Entries can currently be made in English and Spanish. Talton is attempting to incorporate more languages in their TellMate system. Medical staff review and triage sick call requests daily at 2300. Previous FMC Site Visit May 2018: All areas within this category had 100% compliance.							
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	7/9/2019	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			5	5	5	5	5	
Total Met:			5	5	5	5	5	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Panic attack/heart palpatations	Yes	Yes	Yes	Yes	Yes	
2		Thoughts of self-harm	Yes	Yes	Yes	Yes	Yes	
3		Fall injury	Yes	Yes	Yes	Yes	Yes	
4		Abdominal pain	Yes	Yes	Yes	Yes	Yes	
5		Seizure	Yes	Yes	Yes	Yes	Yes	
6			Select	Select	Select	Select	Select	
7			Select	Select	Select	Select	Select	
8			Select	Select	Select	Select	Select	
9			Select	Select	Select	Select	Select	
10			Select	Select	Select	Select	Select	

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ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit March 2017 Follow-up)

Facility Name- Imperial Regional Detention Facility
Address (Street and Name)- 1572 Gateway Road
City, State and Zip Code- Calexico, CA 92231
County- Imperial
Date[s] of FMC Follow-up- Within 30 days of approved UCAP
Complete and Return to ICE HQ No Later Than: September 25, 2017
Facility Corrective Action Plan Assigned to – HSA (b)(6); (b)(7)(C)
Date of Final Submission:

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Reviews) Imperial Regional Detention Facility (San Diego AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
Dental scheduled appointments are entered into the Offender Data System (ODS) computerized database, but are not written in the narrative section of the medical chart. Only when an appointment needs to be rescheduled does a notation of the scheduled appointment appear in the medical chart. (Quality Of Care (QOC))	(b)(5)	HSA conducted verbal guidance on 3/13/2017 to Dentist and Dental Assistant regarding dental scheduled appointments to be entered into the Offender Data System (ODS) and correspondingly written in the narrative section of the medical chart. Upon monthly chart audits done in April and May 2017, dental charts reflect 100% compliance per internal CQI.	5/31/2017 Resolved finding per FMC September 2017 site visit.

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Gender is not included among identifying information in medical charts all charts reviewed. (QOC)	(b)(5)	Gender identification was added to demographics on all labels in the ODS system to identify information in the medical charts on 3/16/17. All charts have the gender included in the demographics.	3/16/2017 Resolved finding per FMC September 2017 site visit.
All previous months of Medication Administration Records (MARs) were not included in the medical record. (QOC)		All MAR's are filed in the medical records within a reasonable time. On 3/31/17, there was a monthly meeting conducted to inform all medical personnel to file the MAR's away within appropriate time (No more than two weeks from print out). Filing of the MAR's are also being track in our monthly QI tool kit.	3/31/2017 Resolved finding per FMC September 2017 site visit.
Annual dental examination refresher training for registered nurses is not being provided by the Dentist. (QOC)		This is not a mandatory requirement; however, education will be included in our monthly meetings to include educational materials and at least one dental specific in-service provided to medical staff per calendar year. **IRDF NOV 2017 Update:** Per the HSA, the Dentist or designee, will provide a dental	Ongoing- to be noted on future UCAP.

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		educational in-service at the January 2018 monthly staff meeting. This in-service will include signs and symptoms for RNs to focus on during a dental assessment. The facility does not want to initiate annual dental refresher training at this time until they have approval from MTC Corporate.	
Documented time urgency is not included on the order for specialty care or diagnostic services. (QOC)	(b)(5)	Providers will document the time urgency for specialty diagnostics. All providers will be instructed to document; routine, stat, within two days, etc. Compliance will be evaluated and will be added starting in October 2017 and forward to the CQI tool kit for internal audits. **IRDF NOV 2017 Update:** CQI tool kit sent to FMC to review. Compliance less than 100% for October 2017.	Ongoing due to less than 100% compliance on CQI tool- to be noted on future UCAP.

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A delay in reviewing specialist reports for specialty care and diagnostic services was noted. (QOC)	(b)(5)	Medical records personnel were verbally instructed to obtain the reports in a timely manner and to place the findings for a provider chart review. Reports are obtained from specialty consultants and are given to the providers for review as soon as possible.	3/31/2017 Resolved finding per FMC September 2017 site visit.
A medical chart with a seizure diagnosis did not have a bottom bunk ordered. (QOC)		HSA conducted verbal guidance on 3/10/17. Providers were made aware of issue. Seizures as well as other conditions per Providers discretion are given low bunk low tear to ensure patient safety and appropriate accommodations to the patients in need.	3/10/17 Resolved finding per FMC September 2017 site visit.
Prior CAP findings:			
A chronic care medical chart was not seen for a full physical evaluation until 21 days after arrival. A complete health assessment should be completed within two business days if a chronic diagnosis is present. (PBNDS 2011)		**IRDF March 2016 Update**: Nurses have been educated regarding intake screenings and when to refer detainees to a provider. Staff received additional training on February 19, 2016 regarding intake findings that should be referred to NP and/or	

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		Provider. The facility has developed a committee to monitor for compliance in the month of February. A nurse was assigned to monitor the CQI program in addition to the committee that was already in place. **FMC Update August 2016**: Compliance has decreased from 80% on the February 2016 site visit to 70% compliance during the August 2016 site visit. **FMC Update March 2017**: Compliance has increased to 95%. Remains a finding. All physicals are completed upon arrival. HSA and Medical Director chose to waive the 14 day grace period and now all new intakes have the physical assessment, Dental assessment and Mental Health assessment upon arrival for all intakes. A QI study was performed and it	4/18/2017 Resolved finding per FMC September 2017 site visit.

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		was concluded that we were 100 percent compliant. The study was concluded on 4/18/17. This is also being traced in the CQI tool kit for internal audits.	
Medical charts do not have a separate area labelled consistently for medical housing in the observation housing unit. This continues to be a finding during the March 2017 site visit. (PBNDS 2011).	(b)(5)	Medical Records staff was educated to resume the file separation process. Chart dividers are available and implementation will start on August 10, 2015. A daily progress note sheet has been developed and implemented on 11/8/14 for use in patients housed in the observation unit. Chart dividers were also implemented on 11/8/14 for organization and uniformity in filing system. Staff announcement of such change took place on 11/8/14. FMC Update: 9/28/15 – Progress notes mixed in with other	

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DHS-ICE-20-0618-A-000897

		medical records. **FMC FEB 2016 Update:** Medical charts do have a divider system in place as of Feb site visit. However, the Observation Unit housing is not a separate area of the medical chart. **IRDF March 2016 Update:** Medical charts are divided by the use of tabs, with the exception of medical observation. We are in the process of make this divisions and separating the medical observation from the rest of the chart. Expected completion date is 4/22/16 **FMC AUG 2016 Update:** The medical observation housing unit is not labelled separately in the majority of charts. **FMC MARCH 2017 Update:** Compliance increased to 90% compared to 29% compliance during August 2016 site visit.	

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		Remains a finding. All charts have dividers to distinguish the medical observation unit. The original idea was for the medical records to place the OHU tab only in the OHU charts, however, HSA decided that all charts without exception will have OHU tabs to assure 100 percent compliance. As of 9/26/17, all charts have the OHU dividers.	9/26/2017 Resolved finding per FMC September 2017 site visit.
Upon intake, nurses continue prescribed medications without first consulting and getting orders from a mid-level provider or MD to continue the medication. (Outside RN scope of practice, PBNDS 2011)	(b)(5)	**FMC MARCH 2017 Update:** Compliance increased to 70% compared to 0% compliance during the August 2016 site visit. Remains a finding. HSA provided an in-service to nurses on March 31, 2017 during the monthly staff minutes. **IRDF OCT 2017 Update:** HSA will provide a refresher training to assure 100 percent compliance. The nurses will be	Verified by FMC on 11/6/2017. Resolved finding.

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DHS-ICE-20-0618-A-000899

		trained to obtain a providers orders to continue; change or discharge medications. Provider on call will give further orders for continuation. Medications will not be given without first consulting with provider. This will also be monitored in the CQI internal audit. **IRDF NOV 2017 Update:** New policy memo has been created. Staff meeting on 9/29/2017 discussing new policy sent to FMC. CQI Chart review audits began in OCT 2017 with 100% compliance for OCT 2017.	
Staffing levels have been inconsistent due to changes in leadership, voluntary resignations and the use of scheduled staff to perform coverage for administration. During the September 2015 site visit, staffing had improved; however, there were still two vacancies: part-time nurse practitioner (NP) and full-time registered nurse (RN). Since the site visit, the Health Services Administrator has been on extended medical leave projected to last until July 2016 and the DON has been filling the role of DON and acting HSA. (PBNDS	(b)(5)	HSA is on medical leave again until July 2016. DON is currently working as both a DON and acing HSA. MTC Medical Corporate and IRDF Human Resources will work to fill the open position. Emphasis will be placed on hiring a RN position. DON has been filled effective 8/17/15. Currently vacancies: 1 RN and 1 dental assistant.	Resolved finding per FMC September 2017 site visit.

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2011)		**FMC MARCH 2017 Update:** HSA position remains filled since January 2016. Dental assistant position has been filled since November 2015.	
No psychiatrist is available to physically assess detainees during the week. (Quality of care)	(b)(5)	IRDF staffing report reflects a psychiatrist for 16 hours per week, which is currently being met. MTC Medical will explore options to increase the availability of the psychiatrist. **FMC FEB 2016 Update**: Additional psychiatrist hours are not being added at this time given the current workload. Current hours are sufficient to cover current workload. **FMC MARCH 2017 Update:** Current mental health staffing is sufficient for facility needs. Additional psychiatrist working hours during the week are not needed per the HSA.	Resolved finding per FMC September 2017 site visit.

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
07/08/2019	05/21/2018	Imperial Regional Detention Facility

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	San Diego AOR

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☒ Other: PBNDS 2016 revisions

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
637	574	63	7	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
21	12	9	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 618-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 618-(b)(6); (b)(7)(C)
Address: 1572 Gateway Road Calexico, CA 92231	Address: 1572 Gateway Road Calexico, CA 92231

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No medical care deficiencies were found during this site visit.

Previous Site Visit May 2018:
Resolved finding: Registered Nurses (RNs) are no longer ordering prescription medications outside their scope of practice.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
79	4

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No chronic care deficiencies were found during this site visit.

Previous Site Visit May 2018:
No deficiencies.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
All medical staff are current on hunger strike training. No deficiencies were noted.

Previous Site Visit May 2018:

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No deficiencies.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	36

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Detainees are placed in a secure one-to-one observation status in a fully modified cell in the observation housing unit (OHU) when a suicidal ideation or attempt is made. Detainees are followed up by a qualified behavioral health provider at least every 24 hours while on suicide watch. The facility has one designated suicide watch room, which has been modified to be without structures that could aid in self-harm. If a second detainee requires a 1:1 suicide watch, they are sent to Alvarado Parkway Institute, an inpatient psychiatric hospital, when appropriate.
No deficiencies noted.

Previous Site Visit May 2018:
No deficiencies.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Previous Site Visit May 2018:
No deficiencies.

Other Observations

The Imperial Regional Detention Facility (IRDF) IHSC Site Visit was conducted July 8, 2019 through July 12, 2019. The site visit was completed by (b)(6); (b)(7)(C) the San Diego Field Medical Coordinator(FMC). 52 charts were reviewed in detail.

IRDF is a dedicated ICE IGSA with MTC as the contractor for both security and medical personnel. The average length of stay at IRDF is 104 days. Per local ERO, plans for IRDF bed expansion are pending review from ERO HQ Custody Management Division pursuant to the California wide detention bed procurement.

Review of medical staff training was found to have mandatory training up to date. Personnel files were organized and filed appropriately in the HSA's office. Review of 20 randomly selected medical staff credential files had their required license and BLS card current.

Most recent audits:
Department of Justice (DOJ) audit: June 3, 2019- June 6, 2019.
Nakamoto audit: January 15, 2019 - January 19, 2019.
American Correctional Association (ACA) audit: November 12, 2018 - November 14, 2018.
National Commission on Correctional Health Care (NCCHC) audit: January 30, 2017 - February 1, 2017.

Deficiencies for Areas Evaluated

Quality of Care findings (not deficiencies):

Hypertension:
One of eight (13%) charts was seen by a MD/NP after 19 days of illness identification rather than in 14 days for stable patients with hypertension. The physical exam (PE) was conducted by a RN on the day of arrival.

Laboratory Testing:
Two of ten (20%) charts reviewed did not have documentation that the patient was advised of their laboratory results.

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Medical Record-Keeping Practices:
Three of ten (30%) charts did not have all medical and mental health diagnoses listed on the problem list.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC Tool.

Health Assessment

See QMC Tool.

Urgent Care (Sick Call)

See QMC Tool.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC Tool.

Medication Administration Practices

See QMC Tool.

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Continuity of Medication

See QMC Tool.

Mental Health Screen

See QMC Tool.

Medical Recordkeeping Practices

See QMC Tool.

Pregnant Women

See QMC Tool.

Dental Care

See QMC Tool.

Additional comments:
A RN evaluates dental sick calls through a face-to-face encounter within 24 hours of receiving the sick call complaint. The RN then places a chart review for the dentist to review the sick call assessment. The dental assistant schedules the patient to be seen within 21 days based on the acuity of the complaint in the RN assessment.

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Acute Laboratory Testing

See QMC Tool.

Diagnostic Services and Specialty Care Access

See QMC Tool.

Mental Health Treatment Planning

See QMC Tool.

Treatment of Disability

See QMC Tool.

Complaints and Grievances

See QMC Tool.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC Tool.

Human Immunodeficiency Virus (HIV)

See QMC Tool.

Hypertension

See QMC Tool.

Asthma

See QMC Tool.

Seizure Disorder

See QMC Tool.

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Recommendations

(b)(5)

Facility Actions

IHSC San Diego FMC met with the new Assistant Warden and acting Warden (until a permanent replacement is hired) during the site visit. A closeout meeting was conducted with the Health Services Administrator (HSA) on July 12, 2019. Quality of care findings were communicated daily to the HSA and DON throughout the five day site visit. FMC met with IRDF AFOD while on-site and notified the SND Field Office there were no findings of concern.

Additional Comments

The facility is planning to have their next NCCHC audit in January 2020.

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809- (b)(6); (b)(7)(C)	Date Prepared: 08/21/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 689- (b)(6); (b)(7)(C)	Date Reviewed: 10/15/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 10/18/2019

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
05/21/2018	09/18/2017	Imperial Regional Detention Facility

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	San Diego AOR

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☒ Other: PBNDS 2016 revisions

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
726	660	66	0	1

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
18	8	10	0	3	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 618-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 618-(b)(6); (b)(7)(C)
Address: 1572 Gateway Road Calexico, CA 92231	Address: 1572 Gateway Road Calexico, CA 92231

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No medical care deficiencies were found during this site visit.

Resolved findings:
PBNDS 2011: 4.3 Medical Care, B. Designation of Authority; Health care personnel perform duties within their scope of practice for which they are credentialed by training, licensure, certification, job description, and/or written standing or direct orders by personnel authorized by law to give such orders.

Registered Nurses (RNs) are no longer ordering prescription medications outside their scope of practice. In all ten charts reviewed, there were signed mid-level provider (MLP)/Medical Doctor (MD) orders within the medical chart to continue medications listed on the receiving transfer summary.

Previous Site Visit September 2017:
Two of ten charts had upon intake, nurses continuing previously prescribed medications from other facilities without receiving orders from a mid-level provider or physician at the facility to continue the medication. The detainee's medications that they arrive to the facility with are placed on pill line (except for inhalers). Only medications that are labeled appropriately in separate bottles/blister packs are continued until re-ordered by the facility provider. The provider co-signs the order usually within 24 hours. (Outside RN scope of practice)

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
56	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No current deficiencies noted.

Previous Site Visit September 2017:
No deficiencies.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	13

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

All medical staff are current on hunger strike training. No deficiencies were noted.
Two hunger strikes charts were available to review.

The Clinical Director (CD) is now willing to compose a declaration for a force feed court order if needed for a detainee's deteriorating health. The CD will not order or supervise a force feed within the IRDF facility. The detainee will be sent off-site to the nearest accepting hospital for treatment and monitoring.

Previous Site Visit September 2017:
At time of review, the clinical director will not compose a declaration for a force feed court order and will not provide orders for an involuntary force feed within the IRDF facility. No deficiencies were noted in the three charts reviewed.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	59

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Reviewed ten medical records. Detainees are placed in a secure one-to-one observation status in a fully modified cell in the observation housing unit (OHU) when a suicidal ideation or attempt is made. Detainees are followed up by a qualified behavioral health provider at least every 24 hours while on suicide watch.

The facility has one designated suicide watch room, which has been modified to be without structures that could aid in self-harm. If a second detainee requires a 1:1 suicide watch, they are sent to Alvarado Parkway Institute, an inpatient psychiatric hospital, when appropriate.

Previous Site Visit September 2017:
No deficiencies noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Previous Site Visit September 2017:
No deficiencies noted.

Other Observations

IHSC FMC Site Visit May 21-25, 2018.

62 total charts reviewed.

Facility Data:
Imperial Regional Detention facility (IRDF) is a dedicated IGSA with MTC as the contractor for both security and medical personnel.
The average length of stay is 97 days.

In the observation housing unit (OHU) located in the medical department there are six negative pressure rooms, one designated suicide watch room, and seven non-negative pressure rooms. (b)(7)(E)

(b)(7)(E)

The CLIA certification expires on 7/28/2019. The medical department was kept clean. Sharps containers and biohazard trash were maintained below the maximum level. A random sharps inventory check was conducted by the FMC with all items accounted for appropriately. The pharmacy was kept organized with inventory logs maintained up to date. The door to the pharmacy is kept locked at all times.

Review of medical staff training was found to have mandatory training up to date. Personnel files were organized and filed appropriately in the HSA's office. Reviewed 33 of 33 medical staff credential files. All had their required license and BLS card current.

(b)(7)(E)

Deficiencies for Areas Evaluated

Quality of Care findings (not deficiencies):

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-In one chart reviewed, the period of time from the medication order to the first dose was more than 24 hours. (Quality of Care)

-In one chart reviewed, dental treatment was rescheduled repeatedly causing a delay in care. (Quality of care)

-A documented time urgency is not consistently included on the order for specialty care or diagnostic services. (Quality of care)

-In one chart reviewed for laboratory testing, there was not documentation showing the patient was advised of their laboratory results. (Quality of care)

-In one chart reviewed the patient was not re-evaluated every 30 days until the off-site appointment was completed. (Quality of care)

-In another chart reviewed, the facility clinician did not review the off-site specialist's report within seven days of the date the service was performed. (Quality of care)

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

Health Assessment

20 charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within 20 charts reviewed met 100% audit tool criteria.

Urgent Care (Sick Call)

Four charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within three charts reviewed met 100% audit tool criteria.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Five charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within four charts reviewed met 100% audit tool criteria.

Medication Administration Practices

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

In one chart reviewed, a psychotropic medication was refused six times. The mental health provider discontinued the medication. There was no notification within the medical chart of the consecutive refusals, instead the notification was made via the ODS computer system.

Additional comments:
47% of patients were on self-administered medication, also called keep on person (KOP) medication. The month of May 2018 MARs had 4% consecutive refusals. No MARs reviewed had blanks.

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Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria. 40% of patients were on self-administered medication. This percentage dropped from 50% provider ordered KOP medication during the previous review. MTC Corporate has recommended that NSAIDS (non-steroidal anti-inflammatory drugs) are only to be administered via pill line for a maximum of 10 doses ordered at one time.

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Continuity of Medication

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

In one chart reviewed, the period of time from the medication order to the first dose was more than 24 hours. The detainee arrived at IRDF on Friday 3/2/2018. The detainee was taking Metformin 850mg per the transfer summary and did not arrive with the medication in his property. Diamond pharmacy does not deliver medications on the weekends. The detainee received the medication on 3/5/2018. Blood sugar checks were taken on 3/3/18 and 3/4/18 to monitor his blood sugar levels.

The remaining areas within this category had 100% compliance.

Additional comments:
In all ten charts reviewed, there were signed provider orders within the medical chart to continue medications listed on the receiving transfer summary.

Previous Site Visit September 2017:
Though all findings meet the audit tool criteria, two of ten (20%) charts reviewed had the nurse continuing medications from intake without a IRDF provider order. This is outside the RN scope of practice.

Mental Health Screen

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.
In one chart reviewed, the mental health provider attempted to evaluate the patient two days after the intake screening for a routine mental health referral. The detainee refused the initial mental health evaluation.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

Medical Recordkeeping Practices

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Additional comments:
The facility currently uses paper charting for medical documentation. There has been discussion between IHSC and ERO proposing a contract modification to implement an electronic health record in the future.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

Pregnant Women

Four charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Additional Comments:
Pregnancy tests are performed on all females age 18-65 during intake screening.

Previous Site Visit September 2017:
All findings within two charts reviewed met 100% audit tool criteria.

Dental Care

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Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

In one chart reviewed, dental treatment was rescheduled repeatedly causing a delay in care. The Dentist saw the patient on 4/9/2018 for a tooth pain sick call and scheduled a filling to occur on 4/23/2018. Due to staff illness, the filling was rescheduled to 5/10/2018. The 5/10/18 filling appointment did not occur due to the patient being in court. The filling appointment was then rescheduled to 5/30/2018. The filling was completed on 5/29/2018 by the Dentist.

Additional comments:
A RN evaluates dental sick calls through a face-to face encounter within 24 hours of receiving the sick call complaint. The RN then places a chart review for the dentist to review the sick call assessment. The dentist schedules the patient to be seen within 30 days based on the acuity of the complaint in the RN assessment.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

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Acute Laboratory Testing

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

In one chart reviewed, the patient had baseline labs drawn for hypertension and diabetes. There was no documentation in the medical chart of the patient being advised of his lab results.

All other areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

Diagnostic Services and Specialty Care Access

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

Five of ten (50%) charts had a documented time urgency included on the order for specialty care or diagnostic services.

In one chart reviewed the patient was not re-evaluated every 30 days until the off-site appointment was completed. An optometry referral was ordered on 3/6/2018. The off-site appointment was completed on 4/16/2018.

In another chart reviewed, a mammogram was completed on 4/26/2018. The Nurse Practitioner did not notate that the study results were reviewed until 5/9/2018.

Previous Site Visit September 2017:
Three of ten (30%) charts had a documented time urgency included on the order for specialty care or diagnostic services. All other findings within ten charts reviewed met 100% audit tool criteria.

Mental Health Treatment Planning

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within ten charts reviewed met 100% audit tool criteria.

Treatment of Disability

Four charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Additional Comments:
The facility maintains a current list of all patients with disabilities.
ADL assistance was not needed by any of the four patients in the charts reviewed.

Previous Site Visit September 2017:
All findings within two charts reviewed met 100% audit tool criteria.

Complaints and Grievances

Two medical grievances were submitted from February 2018 through April 2018. Both grievances were appropriately addressed within one business day of receipt.

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Previous Site Visit September 2017:
There were ten medical grievances from June 2017 through August 2017. The facility's grievances do not reveal any possible barriers to care or repetitive concerns that could affect clinical care. All grievances were addressed within five working days of receipt.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Eight charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.
In one chart reviewed, aspirin was not clinically indicated to be prescribed due to the detainee's age and diabetes being the only chronic condition.
In three charts reviewed, the HgbA1C was under the 8.0 goal.

Previous Site Visit September 2017:
Four of five (80%) charts had the blood sugar measured and recorded on intake. All other findings within the five charts reviewed met the audit tool criteria.

Human Immunodeficiency Virus (HIV)

Seven charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

In one chart reviewed, the detainee was not seen by an HIV or Infectious Disease (ID) specialist within 30 days of HIV identification. The detainee arrived to IRDF on 12/25/17 and saw the off-site ID specialist on 3/13/18. The Clinical Director (CD) of IRDF spoke with the ID doctor via telephone and together consulted on the plan of care to wait on the ID referral until all lab work returned. The detainee's CD4 count was normal, and there was an undetectable viral load. The ID doctor advised the CD to continue the medication Atripla once daily until the off-site ID appointment.

All remaining areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within four charts reviewed met 100% audit tool criteria.

Hypertension

Ten charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within four charts reviewed met 100% audit tool criteria.

Asthma

Four charts were available to be reviewed using the Quality of Medical Care Inspection Worksheet.

All areas within this category had 100% compliance.
Two of four charts did not have a peak flow completed at the initial physical exam which is conducted the same day as the intake screening. This was due to neither patient stating they had a diagnosis of asthma during their intake medical screening.

In one chart reviewed, the asthma diagnosis was given after the detainee had an urgent care complaint of shortness of breath and wheezing one month after arrival to the facility.
In another chart reviewed, the detainee placed a sick call three days after arrival to the facility stating he had asthma since age six.

Previous Site Visit September 2017:
All findings within three charts reviewed met 100% audit tool criteria.

Seizure Disorder

Four charts were available to be reviewed using the Quality of Medical Care Inspection

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Worksheet.

All areas within this category had 100% compliance.

Previous Site Visit September 2017:
All findings within two charts reviewed met 100% audit tool criteria.

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Recommendations

(b)(5)

Facility Actions

A closeout meeting was conducted with the Health Services Administrator (HSA) on 5/25/2018. FMC findings were communicated daily to the HSA and DON throughout the five day site visit.

The SND Field Office was informed there were no standards deficiencies found during this site visit.

Additional Comments

The IRDF September 2017 UCAP was approved by IHSC leadership on 2/6/2018. All findings were addressed and completed.

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809- (b)(6); (b)(7)(C)	Date Prepared: 07/20/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 689- (b)(6); (b)(7)(C)	Date Reviewed: 08/07/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 08/09/2018

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
03/06/2017	08/26/2016	Imperial Regional Detention Facility

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	San Diego AOR

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
650	589	61	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
11	7	4	0	4	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 618- (b)(6); (b)(7)(C)	Phone Number: +1 (760) 618- (b)(6); (b)(7)(C)
Address: 1572 Gateway Road Calexico, CA 92231	Address: 1572 Gateway Road Calexico, CA 92231

Medical Care

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☒ 3 Standards ☐ >3 Standards

Description of deficiencies:

No new medical care deficiencies found during this site visit.

Continued deficiency finding:
PBNDS 2011: 4.3 Medical Care, B. Designation of Authority; Health care personnel perform duties within their scope of practice for which they are credentialed by training, licensure, certification, job description, and/or written standing or direct orders by personnel authorized by law to give such orders.

Three of ten (30%) charts had upon intake, nurses continuing previously prescribed medications from other facilities without first consulting and receiving orders from a mid-level provider or physician at the facility to continue the medication. (Outside RN scope of practice)

PBNDS 2011: 4.3 Medical Care, L. Comprehensive Health Assessment; Each facility's health care provider shall conduct a comprehensive health assessment ... within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.

19 of 20 (95%) had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or have a chronic illness.

PBNDS 2011: 4.3 Medical Care, F. Facilities, 3. Medical Housing; If there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel ...maintenance of a

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separate medical housing record distinct from the complete medical record.

-OHU medical housing had a separate section designated in the medical chart in nine out of ten (90%) charts reviewed.

Resolved findings:
-All four of four (100%) mid-level provider encounters involving a sensitive area exam had a chaperone's name listed.

-No charts of detainees who identify as transgender were available to review.

Previous Site Visit August 2016:
-Upon intake, nurses continue prescribed medications without first consulting or getting approval from a mid-level or MD to continue the medication. (Outside RN scope of practice)

-A nurse performed a urine dipstick without a provider's order.(Outside RN scope of practice)

-Lack of documentation of a chaperone during private examinations remains deficient. Four of six (67%) charts reviewed with a sensitive area exam had a chaperone documented.

-Eight of ten (80%) had a complete health evaluation within 14 days.

-Four of 14 (29%) charts had a separate section labeled "OHU" for medical housing admissions.

-Transgender detainees who were already receiving hormone therapy when taken into ICE custody shall have continued access. One chart had a transgender detainee who had been on hormone therapy for years not continued on hormone therapy because she was not actively taking the medication for 15 days prior to entering custody.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
54	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Current Deficiencies
No current deficiencies noted.

Previous Site Visit August 2016:
No deficiencies.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No hunger strike charts available to review.

All medical staff current on hunger strike training.

Previous Site Visit August 2016:
No deficiencies noted.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	21

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Reviewed 10 of 10 medical records. Detainees are placed in a secure one-to-one observation status in a modified cell in the observation housing unit (OHU) when a suicidal ideation or attempt is made. Detainees are followed up by a behavioral health provider at least every 24 hours when on suicide watch.

Security staff post orders in the OHU protocol binders are noted to include the allowance of personal hygiene supplies and showers when on suicide watch. The facility has one designated suicide watch room, which has been modified to be without structures that could aid in self-harm. If a second detainee requires a 1:1 suicide watch, they are sent to Alvarado Parkway Institute, an inpatient psychiatric hospital, when appropriate.

Previous Site Visit August 2016:
There is one designated suicide watch room, without furniture or objects that could be used for self-harm. The OHU room adjacent to the suicide watch room is sometimes used as a "step-down" room, where detainees can be moved to as their suicide watch is ending. This room has a sink, toilet, and metal bed frame that could be used for self-harm.
The HSA insists the "step-down" adjacent room is never used for actively suicidal patients.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Previous Site Visit August 2016:
No deficiencies noted.

Other Observations

IHSC FMC Site Visit March 6- March 10, 2017.

48 total charts reviewed.

Facility Data:
Imperial Regional Detention facility is a dedicated IGSA with MTC as the contractor for both security and medical personnel.
The current average length of stay is 80 days.

In the observation housing unit (OHU) located in the medical department there are six negative pressure rooms, one suicide watch room, and seven non-negative pressure rooms. There is a desk within sound of the OHU rooms where a security staff member is posted; however, the windows of some of the OHU rooms are difficult to see through from the desk due to the facility layout. The officer posted there makes rounds no less than every 30 minutes, and more frequently, as the provider orders.

Staffing-

(b)(7)(E)

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(b)(7)(E)

The psychiatrist remains available on weekends for medication review and adjustment and takes phone calls during the week in regards to medication adjustments. The psychiatrist provides telephone orders for psychiatric medications for new arrivals and evaluates the detainee at a later date when an appointment is available. The LCSW evaluates detainees pending the psychiatrist's evaluation.

The clinical director routinely see chronic care patients every 21-45 days rather than waiting every 90 days.

Review of medical staff training was found to have mandatory training up to date. Personnel files were organized and filed appropriately in the HSA's office. Reviewed (b)(7)(E) medical staff credential files. All had their required license and BLS card current.

(b)(7)(E)

During the walk through of the housing units, the FMC noted soap dispensers were now installed (new since prior site visit) in the majority of housing units. The medical clinic is kept clean, mopped, trash and bio-harzard bins emptied before full, and sharp containers were replaced when full.

Deficiencies for Areas Evaluated

Deficiencies are resolved when findings are 100%.

Three of ten (30%) charts had upon intake, nurses continue previously prescribed medications from other facilities without first consulting and getting approval from a mid-level or MD to continue the medication. (Outside RN scope of practice)

19 of 20 (95%) had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or have a chronic illness. (PBNDS 2011)

OHU medical housing had a separate section designated in the medical chart in nine out of ten (90%) charts reviewed. (PBNDS 2011)

Audit Tool findings (not deficiencies):

Dental scheduled appointments are entered into the Offender Data System (ODS) computerized database, but are not written in the narrative section of the medical chart. Only when an appointment needs to be rescheduled does a notation of the scheduled appointment appear in the medical chart. As a medical chart reviewer, it is difficult to determine if/when follow-up appointments are scheduled. (Quality of Care)

Gender is not included among identifying information in medical charts in ten of ten charts reviewed. (Quality of Care)

All previous months of MARs weren't included in the medical record, six of nine did not have a January 2017 MAR included in the medical record. (Quality of Care)

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Annual dental examination refresher training for RN PE and sick call exams is not being provided by the Dentist. (Quality of care)

A documented time urgency is not included on the order for specialty care or diagnostic services. (Quality of care)

A delay in reviewing specialist reports for specialty care and diagnostic services is noted in two out of ten charts reviewed. (Quality of care)

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Suicide Screening

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) charts reviewed had the suicidal patient evaluated by a mental health professional within 24 hours of identification or immediately if the situation was emergent, and the patient was evaluated daily while on suicide watch by a qualified mental health professional. Constant 1:1 monitoring was practiced while the patient was on suicide watch in all ten charts reviewed. Zero of ten (0%) charts had evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch. Documentation that the checks were documented consistently were not available in the medical charts to review. The constant 1:1 documentation of checks are stored in the custody files and were not available to be reviewed at time of site visit.

Additional Comments:

In the previous three months, ten patients were placed on suicide watch.

The facility uses an acceptable suicide risk management screening tool during the intake screening that asks for history of suicide attempts and current suicidal ideation.

Training logs indicate that all screeners and staff in direct contact with detainees are trained to assess suicide risk.

Previous Site Visit August 2016:
All findings met audit tool criteria.

Health Assessment

20 charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. 20 of 20 (100%) charts had the initial screen completed within 12 hours of booking and had timely follow-up for significant findings of acute and chronic conditions. 18 of 18 (100%) charts had a chest x-ray ordered and read. Seven of seven (100%) charts of detainees who screen positive for mental illness or suicide risk were referred for evaluation. 19 of 20 (95%) had a complete health examination including vital signs, adequate medical and behavioral health history, and physical examination by licensed MD/PA/NP/RN within 14 days of booking or within 48 hours if on daily medications or have a chronic illness.

Additional Comments:
In one chart reviewed the detainee arrived to the facility on February 9, 2017. He was seen at a chronic care appointment for hypertension by the clinical director on February 10, 2017; however, the complete health evaluation was not completed until March 3, 2017. This was 21 days after his arrival to the facility.

In 20 charts reviewed, none were noted to have PPDs placed during intake as chest x-rays are performed. All charts are noted to have chest x-ray results in the medical record.

Previous Site Visit August 2016:
87% of charts had timely follow up of a chronic or acute condition. 80% had a complete health evaluation with 14 days or 48 hours if chronic in nature.

Urgent Care (Sick Call)

Eight charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Eight of eight (100%) charts had timely and appropriate evaluation by nursing staff, care was delivered within the scope of the nurse's license, vital signs were documented, a nursing referral to a MD/PA/NP/DMD submitted within 24 hours where appropriate, and if referred, an MD/PA/NP/DMD assessment and plan documented.

Additional Comments:
All telephone orders documented by the RN were co-signed by the ordering provider.

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Previous Site Visit August 2016:
86% charts had timely and appropriate evaluations by nursing staff within the scope of the nurse's license. 100% had vital signs documented. 83% had referrals to MD/MLP within 24 hours where appropriate, and 100% had a MD/MLP assessment and treatment plan documented.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Six charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Six of six (100%) charts had an outbound progress note, discharge documentation from the hospital or emergency department in the chart, and an inbound assessment. Zero of six (0%) had evidence that earlier intervention might have prevented deterioration to the point of need for hospital care. Five of five (100%) had assessments that reflect hospital findings and concurrence with hospital recommendations.

Previous Site Visit August 2016:
No charts reviewed had evidence that earlier intervention would have prevented the need for emergency care. All findings met audit tool criteria.

Medication Administration Practices

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Two of two (100%) charts had documentation that the prescribing clinician was notified of consecutive refusals and there was an appropriate response from the clinician.

Additional Comments:

The facility has policy "Pharmaceutical Management" No. 904E.128FNI in place which states "detainees who are on direct observation therapy and refuse medication three consecutive times will be placed on chart review for the medical provider. Upon review the medical provider will determine if medication will be continued, detainee will be seen or medication will be discontinued. Medications for the following conditions will be placed on for review after only one refusal, TB and HIV."

All previous months of MARs were filed in the record filing area. Over the counter medications are provided by both the medical department and can be purchased from the commissary. 50% of patients are on self-administered medication, also called keep on person (KOP) medication. The current and previous month of MARs was not available to review the percentage that have blanks, consecutive refusals, or no shows.

Previous Site Visit August 2016:
Three of six charts had refusals with the prescribing clinician notified with documentation of the consecutive refusals. All six had an appropriate response from the clinician.

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Continuity of Medication

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Seven of ten (70%) charts had the period of time from the completion of intake screening to the ordering of medications [by a provider with medication prescribing privileges] less than 24 hours. Ten of ten (100%) had a less than 24 hour period of time from the order to first dose of medication.

Additional Comments:
Three of ten (30%) charts had the Registered Nurse (RN) continuing medication at intake listed on the transfer summary without a MD/NP/PA at IRDF providing a medication order.

Notations by the RN in the medical chart included, "New arrival with prescription medications, as per protocol, patient to continue .," and "medications to be continued x 30 days as per policy, review with provider next business day."

No IRDF policy was given to the FMC that included a standing order to continue previously prescribed medication at intake without a facility provider order.

Previous Site Visit August 2016:
Upon intake, nurses continue previously prescribed medications from other facilities without first consulting or getting approval from a mid-level or MD to continue the medication. (Outside RN scope of practice)

Mental Health Screen

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Eight of eight (100%) charts of detainees with positive screens for mental illness were evaluated by mental health professionals in a timely manner (emergent= immediately, urgent= within 24 hours; routine= within 7 days).

Previous Site Visit August 2016:
All findings met audit tool criteria.

Medical Recordkeeping Practices

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) were partially compliant for including all identifying information. All ten charts had the detainee name, ID number, and date of birth, but all were missing the gender. Nine of ten (90%) had a current problem list including medical and mental health diagnoses and known allergies. One of ten (10%) was partially compliant, missing the mental health diagnosis on the problem list. Ten of ten (100%) were compliant with receiving screen and health assessment forms, progress notes with documentation of significant findings, diagnoses, treatments, and dispositions preferably in SOAP format, clinician orders for medications signed, consents for medical care and treatment, date and time of each encounter, integrated medical, dental, and mental health record, timely filing within 72 hours, and content organized for easy retrieval of outside records, pertinent diagnostics and consultations. Six of nine (66%) were partially compliant for MARs placed in the record within two weeks of the previous month. Though these charts had the previous month of February in the charts, they did not have the January MAR placed in these six medical records. Three of nine (33%) were compliant with the MAR placed in the medical record within two weeks of the previous month because they arrived in February. Nine of nine (100%) were compliant for acknowledged and dated lab and diagnostic reports.

Seven of seven (100%) were compliant for flow sheets. Five of five (100%) were complaint for signed refusals of care. Three of three (100%) were compliant for results of specialty consultations and referrals acknowledged and dated, and immunization records were applicable. Two of two (100%) were compliant for discharge summaries from ED and hospitalizations, and consolidated medical record with records from prior stays incorporated. Six of six (100%) were compliant for special needs treatment plan where applicable.

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Additional Comments:
Med/psych alert stickers and chronic care labels were listed on all outside covers of chronic care charts reviewed. OHU medical housing had a separate section designated in nine out of ten (90%) charts reviewed. No loose, unfastened papers were noted in medical charts.

Previous Site Visit August 2016:
85% charts reviewed had both a med/psych alert sticker and chronic care stamp on the front of the medical record and had the master list of problems/health issues updated at the front of the chart. 29% charts had a separate section labeled "OHU" for OHU admissions to be kept separate from the rest of the record.

An allergy sticker was noted on charts with documented allergies in all five charts with allergies reviewed. One out of 15 charts had loose papers not fastened into the chart.

Pregnant Women

No charts were available to review for this area.

Local ICE ERO continues to release any female identified as pregnant during intake.

Additional Comments:
Pregnancy tests are performed on all females during intake screening.

Previous Site Visit August 2016:
No pregnant women housed at IRDF at that time.

Dental Care

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts were screened for dental symptoms during the intake process and dental clinical notes included findings, diagnosis, treatment and plans. Nine of nine (100%) were evaluated by a qualified health professional within 48 hours of request. Eight of eight (100%) charts had the patient scheduled for follow-up treatment as recommended.

Additional Comments:
Three of three charts had an annual dental exam/cleaning or refusal form documented in the medical chart for detainees in custody over one year.

Dental scheduled appointments are entered into the Offender Data System (ODS) computerized database, but are not written in the narrative section of the medical chart. Only when an appointment needs to be rescheduled does a notation of the scheduled appointment appear in the medical chart. As a medical chart reviewer, it is difficult to determine if/when follow-up appointments are scheduled.

Annual dental examination refresher training for RN PE and sick call evaluations is not being provided to nursing staff. The dentist provides dental assessment training only upon new RN hire.

Previous Site Visit August 2016:
Five of six charts reviewed had an annual dental exam documented after being in custody for one year and had a dental cleaning.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. One of ten (10%) charts reviewed had blood drawn or test done within one business day of ordered lab. Ten of ten (100%) had the report back within 24 hours for acute labs and within seven days for routine labs, and had clinical acknowledgment and appropriate clinical response. Nine of nine (100%) charts reviewed had the patient notified of laboratory results.

Additional Comments:

The director of nursing checks the lab log daily.

Routine and chronic care labs are not drawn on the next business day because the lab draw schedule is compiled more than 24 hours prior. The facility provider rarely puts a time frame on lab orders; however, all labs done at the facility are drawn within 2-3 business days. Garcia labs consistently provides results to the facility in a timely manner.

For all acute or urgently needed lab work, detainees are transported to El Centro Regional Medical Center within 24 hours for lab draw. IRDF's contracted laboratory provider, Garcia labs, does not process stat labs.

Previous Site Visit August 2016:
No charts were available to review for this area.

Diagnostic Services and Specialty Care Access

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Zero charts had a documented time urgency for the specialty care or diagnostic service ordered. Ten of ten (100%) had the appointment completed within 45 days of the order or within the ordered timeframe. Eight of ten (80%) had the facility clinician acknowledge the specialist's report in the medical record within seven days of the date of service.

One chart reviewed had a mammogram report reviewed by the facility provider ten days after the date of service due to holiday leave of the facility clinician.

Another chart reviewed had a delay from the neurology office faxing the completed report to the facility. The facility provider reviewed the report the day it was received from the neurologist's office, 12 days after the date of service. This delay in reviewing the report was not the fault of the facility and attempts of obtaining the report from the off-site provider was documented in the medical record.

Additional Comments:

None of the appointments took longer than 30 days to schedule. Detainees are referred to appropriate specialists in a timely manner through the MedPAR system.

Previous Site Visit August 2016:
All ten charts had the appointment within the ordered timeframe or within 45 days of the order, and the facility clinician acknowledged the specialist's report within seven days of the date of service. All findings met audit tool criteria.

Mental Health Treatment Planning

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. All ten of ten (100%) charts had a clinical assessment, treatment, and follow-up plan documented. Eight of eight (100%) had a treatment plan updated at a minimum of every 90 days.

Additional Comments:
Two of the ten charts reviewed were for detainees in custody less than 90 days.

Previous Site Visit August 2016:

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All ten charts had a clinical assessment, treatment, and follow-up plan documented. Five of five had a treatment plan updated at a minimum of every 90 days. All findings met audit tool criteria.

Treatment of Disability

No charts were available to review for this area.

Additional Comments:
The facility maintains a current list of all patients with disabilities.

Previous Site Visit August 2016:
No cases of disability available to review.

Complaints and Grievances

13 charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. There were 13 total medical grievances in the last three months. The facility's grievances does not reveal any possible barriers to care or repetitive concerns that could affect clinical care. All grievances were addressed within five working days of receipt.

Three grievances were regarding availability of care.
Three grievances were for denial or refusal of specific care.
One grievance was for delay in care.
Two grievances were for competency/professional skillset of medical staff (the same individual grieved against the same staff member twice).
Three grievances were for attitude, demeanor, or conduct of staff.
One grievance was for "other," which was a sick call request and not a grievance, however it was included on the grievance tracker and responded to within the appropriate time frame.

12 of the 13 were informal grievances, while one was a formal grievance and was referred to the Grievance Appeal Board.

Previous Site Visit August 2016:
There were 28 total medical grievances in the last three months. Nine of these were formal grievances, while 19 were informal in nature. All of the 28 grievances were addressed within five business days.

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Diabetes

Seven charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Seven of seven (100%) charts had a blood sugar recorded on intake, was seen by a mid-level provider or physician for chronic care within 14 days of illness identification, and had lipids measured within one year. Six of six (100%) had a baseline HgbA1c performed within 30 days of intake or within the past three months. Four of four (100%) had the patient followed up at least every 90 days with vital signs, aspirin prescribed as clinically indicated, degree of control documented, and a strategy to attain diabetes control if HgbA1C was above goal.

Additional Comments:
The clinical director follows the American Diabetes Association and Bureau of Prison Diabetes clinical practice guidelines.

Previous Site Visit August 2016:
All findings met audit tool criteria except for three of four (75%) charts had a degree of control documented.

Human Immunodeficiency Virus (HIV)

Six charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Six of six (100%) charts had a CD4+ and viral load completed within 14 days of arrival or within the last three months, had antiretroviral treatment considered and documented, patient was seen by a mid-level provider or physician for chronic care at least every 90 days, and had a chest x-ray completed within 72 hours of problem identification if not already done. Five of five (100%) were seen by a HIV or ID specialist within 30 days of HIV identification.

HIV status was identified by recent laboratory results for three charts reviewed, by medical records for two charts reviewed, and by patient interview for one chart reviewed.

Additional Comments:
In one chart reviewed the clinical director consulted with the off-site infectious disease doctor prior to sending the patient for an ID consult. The ID doctor advised to begin treatment, Atripla 600-200-300mg tablet daily and to get a HIV genotype prior to sending for the ID consult.

The clinical director follows Bureau of Prison HIV clinical practice guidelines.

Previous Site Visit August 2016:
No charts were available to review for this area.

Hypertension

Ten charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Ten of ten (100%) charts had a blood pressure reading at intake and was seen by a MD/PA/NP within 14 days of illness identification. Six of six (100%) had a treatment plan initiated within 14 days of identification if the blood pressure was >140 systolic or >90 diastolic. Nine of nine (100%) had a chronic disease guideline including baseline laboratory testing followed.

Additional Comments:
The clinical director follows the Bureau of Prison Hypertension clinical guidelines and the American Academy of Family Physicians clinical practice guidelines.

Previous Site Visit August 2016:
All findings met audit tool criteria.

Asthma

Three charts were reviewed using the IHSC Quality of Care Audit tool to evaluate this area. Three of three (100%) charts were seen in the chronic care clinic by a mid-level provider or physician within 14 days of illness identification, had a peak flow completed at the chronic care appointment or within the last three months, and had a chronic disease guideline

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followed which addressed disease severity, prescription of medication consistent with severity, and documented degree of control. Three of three (100%) had a peak flow completed at the initial physical exam/intake screening which are conducted the same day.

In September 2016 IRDF began completing the physical health assessment directly after the intake screening. A peak flow is not repeated at both the intake screening and health assessment.

The clinical director follows the American Academy of Family Physicians asthma clinical practice guidelines and the Bureau of Prison Asthma guidelines.

Previous Site Visit August 2016:
75% charts had the patient seen in chronic care clinic within 14 days and had a peak flow completed at the physical exam. 100% charts had a peak flow completed within the last three months and had a chronic disease guideline followed that addressed disease severity, medication prescribed consistent with severity, and degree of control.

Seizure Disorder

One chart was reviewed using the IHSC Quality of Care Audit tool to evaluate this area. One of one (100%) had an appropriate neurological history completed at the initial physical exam, seen in the chronic care clinic by a mid-level provider or MD within 14 days of illness identification, had serum drug levels performed and acknowledged every 3 months until stable, and then every 6 months when indicated, and had a treatment plan established. Zero of one (0%) had orders for a bottom bunk.

Additional Comments:

The clinical director uses the American Academy of Family Physicians guidelines to manage seizures. No other charts with a diagnosis of seizures were available to be reviewed.

In the one chart reviewed, the patient arrived to the facility on 9/13/2016. He was prescribed seizure prophylactic medication for six months by a doctor in India. That treatment ended on 10/31/2016. The patient denied past seizure activity.

Previous Site Visit August 2016:
Two of two charts had a neurological history completed at the initial PE. All three charts had the patient seen in the chronic care clinic within 14 days, had a treatment plan, and orders for a bottom bunk. One detainee should have had serum drug levels performed every three months until stable; however, there was no evidence that serum drug levels were drawn.

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Recommendations

(b)(5)

Facility Actions

A closeout meeting was conducted with the Health Services Administrator and Director of Nursing.

A summary of site visit findings was emailed to the FOD, DFOD over detention, AFOD of IRDF, SDDO/AOIC, HSA, DON, COR, DSM, Warden, and Assistant Warden on March 15, 2017.

Additional Comments

On April 17, 2017, MTC management removed the posted officer from the OHU position. The FMC notified ERO (COR, AFOD, SDDO/AOIC) of this safety concern and PBNDS 2011 deficiency. A contract deficiency report was submitted by ERO to the contractor on April 20, 2017. The COR and AFOD are following up as appropriate.

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End of Report

IHSC, Field Medical Coordinator	
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Phone Number: +1 (202) 809- (b)(6); (b)(7)(C)	Date Prepared: 03/27/2017
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Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360 (b)(6); (b)(7)(C)	Date Reviewed: 06/22/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved: 08/30/2017
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Unit Chief, Medical Case Management
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Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 08/30/2017

Recommendations:

(b)(5)

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CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? American Academy of Family Physicians and BOP asthma guideli

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		NA	NA	NA	NA
5		NA	NA	NA	NA
6		NA	NA	NA	NA
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? American Academy of Family Physicians and BOP asthma guideli

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		NA	NA	NA	NA
5		NA	NA	NA	NA
6		NA	NA	NA	NA
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? American Academy of Fami

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NO
2		NA	NA	NA	NA	NA
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	0 / 1 0 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000944

CHRONIC DISEASE – SEIZURE DISORDER

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? American Academy of Fami

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %	2 /2 100 %	2 / 2 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000945

COMPLAINTS AND GRIEVANCES

DATE 3/10/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 13

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	3	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	3	
Delay(s) in care	1	
Competency/professional skillset of medical staff	2	
Attitude, demeanor or conduct of staff	3	
Other	1	
Total	13	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 9/20/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No. If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 10

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	1	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	1	
Delay(s) in care	3	
Competency/professional skillset of medical staff		
Attitude, demeanor or conduct of staff		
Other	5	(b)(6); (b)(7)(C)
Total	10	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATION

DATE 03/06/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		NO	YES
5		NO	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		NO	YES
10		YES	YES
	Total	7 / 10 70 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000948

CONTINUITY OF MEDICATION

DATE 09/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000949

DENTAL CARE

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	NA
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	NA	YES	NA
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	9 / 9 100 %	10 / 10 100 %	8 / 8 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000950

DENTAL CARE

DATE 9/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item # Measure

1 Was patient screened for symptoms during the intake process?
2 Was patient evaluated by a qualified health professional within 48 hours of request?
3 Do dental clinical notes describe findings, diagnosis, treatment and plans?
4 Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	NA
3		YES	YES	YES	YES
4		YES	YES	YES	NA
5		YES	YES	YES	NA
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	7 / 7 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000951

CHRONIC DISEASE – DIABETES

DATE 3/6/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? ADA and BOP guidelines

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4	Were lipids measured within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated?*
7	Was degree of control (goal GgbA1C<8.0) documented?
8	Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	NA	NA	NA	NA
2		YES	YES	YES	YES	YES	YES	YES	YES
3		YES	YES	YES	YES	NA	NA	NA	NA
4		YES	YES	YES	YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES	YES	YES	YES
6		YES	YES	YES	YES	NA	NA	NA	NA
7		YES	YES	YES	YES	YES	YES	YES	YES
8		NA	NA	NA	NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	7 /7 100%	7 /7 100%	6 /6 100%	7 /7 100%	4 /4 100%	4 /4 10(%	4 /4 100%	4 /4 10C%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 9/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? American Diabetes Association and Bureau of Prison Diabetes clin

Item # Measure

1. Was blood sugar measured and recorded on intake?
2. Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3. Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4. Were lipids measured within one year?
5. Was patient followed at least every 90 days with appropriate vital signs?
6. Was aspirin prescribed, as clinically indicated?*
7. Was degree of control (goal GgbA1C<8.0) documented?
8. Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	NO	YES	NA	NA	NA	YES	NA	NA
2		YES	YES	YES	YES	YES	YES	YES	NA
3		YES	YES	YES	YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES	YES	YES	YES
6		NA	NA	NA	NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	4 /5 80 %	5 /5 100%	4 /4 100 %	4 /4 100 %	4 /4 100 %	5 /5 10(%	4 /4 100 %	3 /3 10(%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 03/06/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Imperial Regional Detention Facility

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	OB/Gyn	NO	YES	N/A	NO
2		Opthalmology	NO	YES	N/A	YES
3		Other	NO	YES	N/A	YES
4		Other	NO	YES	N/A	YES
5		Other	NO	YES	N/A	YES
6		Other	NO	YES	N/A	YES
7		Opthalmology	NO	YES	N/A	YES
8		Neurology	NO	YES	N/A	NO
9		Other	NO	YES	N/A	YES
10		Orthopedics	NO	YES	N/A	YES
		Total	0 / 10 0 %	10 / 10 100%	0 / 0 NaN%	8 / 10 80 %

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000954

American Correctional Association

ACCREDITATION REPORT

Commission on Accreditation for Corrections

ICE Health Service Corps (IHSC)
Eloy Detention Center
Eloy, Arizona

The mission of the Commission on Accreditation for Corrections is to upgrade and improve practices and conditions in adult and juvenile correctional facilities and programs through an accreditation process which is founded on a commitment to accountability, professionalism and respect for basic human rights and which recognizes sound and effective correctional practices, while striving towards excellence in the field of corrections.

AMERICAN OVERSIGHT

FOUNDED 1870

American Correctional Association

206 North Washington Street, Suite 200 • Alexandria, Virginia 22314
703 • 224 • 0000 Fax: 703 • 224 • 0010
www.aca.org

October 19, 2018

ICE Health Service Corps (IHSC)
Eloy Detention Center (IHSC)
Eloy, Arizona

Congratulations!

It is a pleasure to officially inform you that the Eloy Detention Center (IHSC) was accredited by the Commission on Accreditation for Corrections at the American Correctional Association 2018 Congress of Correction on August 6, 2018 in Minneapolis, Minnesota.

Your accreditation represents the satisfactory completion of a rigorous self-evaluation, followed by an outside review by a team of experienced, independent auditors.

Every profession strives to provide a high quality of service to society. To know that you, your staff, and other officials are complying with the requirements of the accreditation process is indeed a statement of a high level of commitment to the staff and persons under your care.

On behalf of the American Correctional Association and the Commission on Accreditation for Corrections, thank you for your commitment to the corrections profession and to the accreditation process.

Sincerely,

Denise M. Robinson

Denise Robinson, Chairperson
Commission on Accreditation for Corrections

AMERICAN OVERSIGHT

FOUNDED 1870
AMERICAN CORRECTIONAL ASSOCIATION
206 NORTH WASHINGTON STREET, SUITE 200 • ALEXANDRIA, VIRGINIA 22314
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For Immediate Release

Eloy Detention Center (IHSC) Awarded National Accreditation

Denise Robinson, Chairperson of the Commission on Accreditation for Corrections (CAC), and Bridget Bayliss-Curren, Director of Standards and Accreditation, American Correctional Association recently announced the accreditation of the Eloy Detention Center (IHSC). The award was presented in conjunction with the American Correctional Association Congress of Correction Conference on August 6, 2018 in Minneapolis, Minnesota.

In presenting the award, Denise Robinson, Chairperson of the CAC, and Lannette Linthicum, President of the American Correctional Association (ACA), complimented the facility on their professional level of operation and their success in completing the accreditation process. The agency is one of over 1,500 correctional organizations currently involved in accreditation across the nation.

The accreditation program is a professional peer review process based on national standards that have evolved since the founding of the Association in 1870. The standards were developed by national leaders from the field of corrections, law, architecture, health care, and other groups who are interested in sound correctional management.

ACA standards address services, programs, health care and security operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for agencies and facilities throughout the world.

The three-year accreditation award granted to the Eloy Detention Center (IHSC) does not signal the end of their involvement in the accreditation process. During the award period, staff will work to improve any deficiencies identified during the audit and maintain continuous compliance with the standards.

AMERICAN OVERSIGHT

FOUNDED 1870

AMERICAN CORRECTIONAL ASSOCIATION

206 NORTH WASHINGTON STREET, SUITE 200 • ALEXANDRIA, VIRGINIA 22314
703 • 224 • 0000 FAX: 703 • 224 • 0010
WWW.ACA.ORG

Congratulations on your accreditation award! You are now a member of the elite in achieving correctional excellence. The certificate you have received is but a small symbol of the enormous dedication and commitment demonstrated by each and every member of your staff to the accreditation process, and I urge you to display it prominently as a continual reminder of the level of professionalism achieved. This is just the beginning of your journey, however, for the true test of excellence is the test of time. It is critical that your operation be able to sustain this achievement over time and be constant through both prosperity and adversity.

Achieving American Correctional Association Accreditation means you have demonstrated your dedication to getting the job done right, and that you are holding your agency to a higher standard.

Thank you for your commitment to the American Correctional Association and the standards and accreditation process.

(b)(6); (b)(7)(C)

JeffreyWashington, Deputy Director
American Correctional Association

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-000958

Overview of the American Correctional Association

The American Correctional Association is the oldest and most prestigious correctional membership organization in the United States. Founded in 1870, ACA currently represents more than 20,000 correctional practitioners in the United States and Canada. Members include all levels of staff from a wide variety of correctional disciplines and programs as well as professionals in allied fields and representatives from the general public. In addition, the Association represents the interests of 74 affiliated organizations whose goals, while similar to those of ACA, focus on specialized fields and concerns within the realm of corrections.

At its first organizational meeting held in Cincinnati, Ohio, in 1870, the Association elected then-Ohio governor and future U.S. President, Rutherford B. Hayes, as its first president. The Declaration of Principles developed at that first meeting became the guidelines for correctional goals in both the United States and Europe.

Since that time, ACA has continued to take a leadership role in corrections and work toward a unified voice in correctional policy. In recent years, one of the Association's major goals has been the development of national correctional policies and resolutions of significant issues in corrections. These policies are considered for ratification at the Association's two annual conferences and ratified policies are then disseminated to the field and other interested groups. ACA has also had a major role in designing and implementing professional standards for correctional practices, as well as methods for measuring compliance with those standards.

The Association conducts research and evaluation activities, provides training and technical assistance, and carries out the regular responsibilities of any professional membership organization, including a full publications program. The Association's two annual conferences, held in varying cities across the nation, attract more than 5,000 delegates and participants each year from the 50 states, U.S. territories, and several foreign countries.

Membership in ACA is open to any individual, agency, or organization interested in the improvement of corrections and the purposes and objectives of the Association. Members include the majority of state, local, provincial, and territorial correctional agencies; individual correctional institutions and local jails, pretrial programs and agencies, schools of criminal justice in colleges and universities, libraries; and various probation, parole, and correctional agencies. Most of ACA's members are employed at the federal, state, and local levels. Members also include more than 200 volunteers affiliated with these agencies as administrators or as members of advisory boards and committees.

AMERICAN OVERSIGHT

Organizational Purposes of the American Correctional Association

Among the most significant purposes of the Association as outlined in its Constitution, are:

> *To provide a professional association of persons, agencies, and organizations, both public and private, who hold in common the goal of improving the profession of corrections and enhancing their contribution to that profession.*
>
> *To broaden and strengthen support for the Association's goals by advocating Association policies, resolutions, positions, and standards to policymakers and the public and by forming coalitions with other professional organizations sharing these goals.*
>
> *To develop standards for all areas of corrections and implement a system for accreditation for correctional programs, facilities and agencies based on these standards. Where feasible, standards shall be based on performance outcome.*
>
> *To conduct or sponsor corrections conferences, congresses, institutes, forums, seminars and meetings.*
>
> *To publish and distribute journals and other informative materials relating to criminology, crime prevention, and corrections and to encourage and stimulate research of these matters.*
>
> *To promote recognition of corrections as a profession, and those who work in corrections as professionals, and to ensure validity of that recognition by encouraging the recruitment and development of highly qualified corrections professionals, and by developing and implementing a certification program for corrections professionals*

In carrying out these purposes, ACA supports programs for policy analysis, demonstration, effective delivery of health services to offender populations and research. ACA also provides testimony, consultation, publications, conferences, workshops, and other activities designed to stimulate constructive action regarding correctional issues.

Standard and Accreditation

Perhaps ACA'S greatest influence has been the development of national standards and the accreditation process. ACA standards address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for correctional agencies in the United States and Mexico.

AMERICAN OVERSIGHT

Organizational Structure of the American Correctional Association

Executive Committee

The Executive Committee is composed of the elected officers of the Association - president, vice president, treasurer, two Board of Governors' members, the immediate past president, the president-elect, and the ACA executive director. The Executive Committee meets at least quarterly and exercises most of the powers of the Board of Governors during the intervals between meetings of the board.

Board of Governors

ACA's bylaws vest control of the Association with an 18-member elected Board of Governors composed of the officers of the Association and five at-large members. To ensure the interdisciplinary nature of the Association, board members must represent the following areas:

Correctional Administration
Institutions
Juvenile
Probation
Parole, Aftercare or Post-Release Supervision
Community Programs
Detention
Education
Health Care

Delegate Assembly

The Delegate Assembly is composed of delegates from the professional affiliates, geographical chapters, membership at-large, Board of Governors, past presidents of ACA, and representatives of each military service. The Delegate Assembly can establish policy, define Association positions on broad social and professional issues, and determine major programs and legislative priorities. They meet at least twice annually, at the Winter Conference and Congress of Correction.

Committees

The majority of the Association's activities take place through committees. Each committee chair reports to the Association's Board of Governors at least twice a year. In this way, the Association collectively benefits from the involvement and contribution of the hundreds of individuals who function on the various committees. Ad-hoc committees are appointed by the president of the Association.

The current committees and councils are:

Committee on Affirmative Action
Committee on Constitution and Bylaws

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Committee on International Relations
Committee on Congress Program Planning
Committee on Legal Issues
Committee on Correctional Awards
Committee on Membership
Committee on Military Affairs \
Council of Professional Affiliates
Council of Dual-Membership Chapters and State and Geographical Affiliates
Nominating Committee
Council on Professional Education
Credentials Committee
Research Council
Eligibility Committee
Resolutions & Policy Development Comm
Committee on Ethics
Performance Standards Committee
Legislative Affairs Committee

Affiliates and Chapters

Affiliates and state chapters are major features of the Association's structure. They represent professional, regional, and state groups across the United States and Canada. Affiliates and chapters contribute to the professional development of all members by providing consultation in their respective areas of interest and by participating in seminars and workshops at ACA's annual conferences.

The following affiliates and chapters are currently associated with ACA:

American Catholic Correctional Chaplains Association
American Correctional Chaplains Association
American Correctional Food Service Association
American Jail Association
American Probation and Parole Association
Arizona Probation, Parole, and Corrs Assn Assn of Paroling Authorities, International Assn of State Correctional Administrators Assn of Women Executives in Corrections International Assn of Correctional Officers Iowa Corrections Association
Juvenile Justice Trainers Association
Kansas Correctional Association
Kentucky Council on Crime and Delinquency
Louisiana Correctional Association Maryland Criminal Justice Association
ACA Mexico Chapter
Jamaica Federation of Corrections
Hawaii Criminal Justice Association
Michigan Corrections Association
Middle Atlantic States Correctional Association
Minnesota Corrections Association
Missouri Corrections Association
District of Columbia Criminal Justice Association
National Association of Adult and Juvenile State Community Corrections Association of Georgia
National Assn of Blacks in Criminal Justice
National Association of Juvenile Corrl Agencies
Oregon Criminal Justice Association
Parole and Probation Compact Administrators Association
Pennsylvania Assn of Probation, Parole, and Corrections
Prison Fellowship
South Carolina Correctional Association
Tennessee Corrections Association
Association on Programs for Female Offenders
Central States Correctional Association
Colorado Correctional Association
Connecticut Criminal Justice Association
Correctional Association of Massachusetts
Correctional Accreditation Managers Assn
Correctional Education Association
Correctional Industries Association
Council of Juvenile Correctional Administrators
Florida Council on Crime and Delinquency
Illinois Correctional Association
Indiana Correctional Association

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International Assn of Corrl Training Personnel
International Community Corrections Assn
National Association of Probation Executives
National Coalition for Mental and Substance Abuse Health Care in the Justice System
National Correctional Recreation Association
National Council on Crime and Delinquency
National Juvenile Detention Association
National Organization of Hispanics in Criminal Justice
Nebraska Justice Association
Nevada Correctional Association
New Jersey Chapter Association
New Mexico Criminal Justice Association
New York Corrections and Youth Svcs Assn
Department of Corrections and Rehabilitation of Puerto Rico Chapter of the American Correctional Association
North American Association of Wardens & Superintendents
North Carolina Correctional Association
Ohio Correctional and Court Svcs Association
Oklahoma Correctional Association
Oregon Criminal Justice Association
Texas Corrections Association
The Salvation Army
Utah Correctional Association Virginia Correctional Association Volunteers of America
Washington Correctional Association
Wisconsin Correctional Association
Wyoming Criminal Justice Association

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Major Activities of the American Correctional Association

Legislation

The American Correctional Association is involved with all major issues affecting corrections today. Members and ACA staff maintain close working relationships with committees of the U.S. Congress and all federal agencies and groups whose decisions affect correctional policy. Expert testimony on a wide range of correctional issues is prepared for congressional committee and subcommittee hearings, and recommendations are provided to federal administrative agencies.

To ensure that the concerns and issues of the corrections profession are represented in proposed legislation and public policy, ACA's legislative liaison is addressing legislative and government concerns that will impact the corrections profession. ACA has established partnerships between chapters and affiliates and other national policy making organizations to present a strong collective voice for correctional reform throughout the world.

Professional Development

The purpose of the Association's Professional Development Department is to plan, promote, and coordinate professional development through training seminars, workshops, and published materials including curriculums, resource guides, and monographs.

ACA's training plan calls for a variety of professional development activities. Nationally advertised workshops cover topics such as training for trainers, management training, community-based employment programs, and stress management. On-site workshops for state and local departments of corrections are offered in curriculum development, supervision, communications, and report-writing skills.

The *Training for Correctional Staff Trainers* workshops further the skills of correctional professionals qualified to initiate and deliver training. These workshops also enable agencies to comply with national standards for accreditation and ensure that training is job-related and professionally developed and presented.

The department also offers correspondence courses to further professional development. More than 6,000 correctional personnel have completed or are in the process of completing ACA's self-instruction training program for correctional officers. This program, developed under the auspices of the National Institute of Corrections, provides 40 hours of basic training in accordance with ACA standards. A score of at least 80 percent on the comprehensive examination must be attained to achieve certification.

The Association has similar courses available for correctional supervisors, juvenile caseworkers, and food service employees. Additional courses which cover report writing skills, correctional management skills, legal issues for probation and parole officers, and legal issues for correctional officers are also available.

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Publications

As one of the leading publishers of practical correctional publications, ACA produces books, videos and lesson plans. Among the wide-ranging subjects available are management, community, security, counseling, law, history and health. These excellent resources for career advancement appeal to practitioners and scholars alike. Directories for every major sector of corrections also are published by ACA.

The following are just a few of the many publications that ACA offers.

Corrections Today is the major corrections magazine in the United States. Published six times a year, the magazine focuses on the interests of the professional correctional employee and administrator. Articles include reports of original research, experiences from the field, discussion of public policy, and the perspectives of prominent practitioners and academicians.

The Juvenile and Adult Directory has been published since 1939. This publication is the only up-to-date, comprehensive directory of all U.S. and Canadian juvenile and adult correctional departments, institutions, agencies and paroling authorities.

The National Jail and Adult Detention Directory was first published in 1978. It is a source of information concerning jails. The directory attempts to list all jails in the United States that house offenders or detainees for more than 48 hours.

The Probation and Parole Directory provides more than 500 pages of information regarding federal, state, and county adult and juvenile probation, parole and aftercare systems in the United States. It includes statistics on caseloads, expenditures and personnel.

Correctional standards are the most significant improvement in correctional programming. As the basis for accreditation, they give administrators a nationally recognized system for upgrading and improving their correctional services. The association currently publishes more than 20 manuals for every correctional discipline.

To aid in the development of policy with relation to accreditation, *Guidelines for the Development of Policies and Procedures* are available for adult correctional institutions, adult parole authorities/adult probation and parole field services, adult local detention facilities, adult community residential services, juvenile detention facilities, and juvenile training schools.

Conventions

ACA hosts two national conventions each year that attract more than 5,000 professionals from all aspects of corrections; the Winter Conference held in January, and the Congress of Correction, held in August. These events include a variety of workshops, exhibits, and seminars devoted to addressing topics specific to the corrections profession.

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Contracts and Grants

The American Correctional Association has a history of successful grant and contract management and administration. ACA has completed contracts and grants of more than $30 million. These diverse initiatives, which are funded through federal and private sources, add to the technical expertise and knowledge of the organization as well as to the total field of corrections.

Performance Based Standards & Expected Practices Accreditation Department

Perhaps ACA's greatest influence has been the development of national standards and the accreditation process. ACA standards address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for correctional agencies in the United States and Mexico.

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Overview of the Commission on Accreditation for Corrections

The Commission on Accreditation for Corrections (CAC) is a private, nonprofit organization established in 1974 with the dual purpose of developing comprehensive, national standards for corrections and implementing a voluntary program of accreditation to measure compliance with those standards.

The Commission was originally developed as part of the American Correctional Association. In 1979, by joint agreement, the Commission separated from the Association in order to independently administer the accreditation program. Between 1978 and 1986, the organizations shared the responsibility for developing and approving standards and electing members of the Commission. On November 7, 1986, the Commission on Accreditation for Corrections officially realigned itself with the American Correctional Association.

The Commission meets at least twice each year. The responsibility of rendering accreditation decisions rests solely with this board. The members of the Commission represent the full range of adult and juvenile corrections and the criminal justice system. They are elected from the following categories:

Correctional Administration
Juvenile Institutions
Probation Parole, Aftercare or Post-Release Supervision
Community Programs
Detention
Education
Health Care
Legal
Architecture
Non-correctional administration

Association Staff

Accreditation activities are supported by the staff of the American Correctional Association, Performance Based Standards & Expected Practices Accreditation Department, under the leadership of the director of the department. Performance Based Standards & Expected Practices Accreditation Department staff is responsible for the daily operation of the accreditation program. Agencies in the process have contact primarily with the accreditation specialist responsible for their state or agency.

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Auditors

Over 600 corrections professionals in the United States have been selected, trained, and employed on a contract basis by the Association. These individuals perform the field work for the Association which includes providing assistance to agencies working toward accreditation, conducting on-site audits of agencies to assess compliance with standards and confirming that requirements are met, and monitoring to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to visiting committees or audit teams, are formed to conduct standards compliance audits of agencies seeking accreditation and reaccreditation.

Auditors are recruited nationally through announcements in prominent criminal justice publications and at major correctional meetings. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All ACA auditors have a minimum of three years of responsible management experience, have received a recommendation from an agency administrator, and have demonstrated knowledge in the substantive area(s) in which they are employed to assist the Association. In addition, all auditors must successfully complete the Association's auditor training and be members of the ACA in good standing.

Traditional Standards and Expected Practices Development

Development of the ACA standards began in 1974 with an extensive program of drafting, field testing, revising, and approving standards for application to all areas of corrections. Since then, over 1,200 correctional facilities and programs have adopted the standards for implementation through accreditation, and many others have applied the standards informally themselves.

In the development of standards, the goal was to prescribe the best possible practices that could be achieved in the United States today, while being both realistic and practical. Steps were taken to ensure that the standards would be representative of past standards development efforts, reflect the best judgment of corrections professionals regarding good corrections practice, recognize current case law, and be clear, relevant, and comprehensive. The standards development and approval process has involved participation by a wide range of concerned individuals and organizations. Twenty-two manuals of standards are now used in the accreditation process:

Standards for Adult Correctional Institutions –Fourth Edition
Performance -Based Standards for Adult Probation and Parole Field Services
Performance -Based Standards for Adult Local Detention Facilities—Fourth Edition
Performance -Based Standards for Adult Community Residential Services —Fourth Edition
Performance -Based Standards for Correctional Industries
Standards for Correctional Training Academies
Standards for Juvenile Community Residential Facilities –3rd Edition
Performance -Based Standards for Juvenile Correctional Facilities -- Second Edition
Standards for Juvenile Probation and Aftercare Services –Second Edition
Standards for Juvenile Detention Facilities —3rd Edition
Standards for Juvenile Day Treatment Programs
Standards for Juvenile Correctional Boot Camps

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Performance -Based Standards for Therapeutic Communities
Standards for Small Juvenile Detention Facilities
Performance-Based Health Care Standards for Adult Correctional Institutions
Performance Based Core Jail Standards-First Edition
Performance Based International Correctional Core Standards- Adult
Performance Based International Correctional Core Standards- Juvenile
Standards for Administration of Correctional Agencies - Second Edition
Standards for Adult Parole Authorities - Second Edition
Standards for Electronic Monitoring Programs
Standards for Adult Correctional Boot Camps Programs

The standards establish clear goals and objectives critical to the provision of constitutional and humane correctional programs and services. The standards include the requirement for practices to promote sound administration and fiscal controls, an adequate physical plant, adherence to legal criteria and provision of basic services. Basic services called for by the standards include the establishment of a functional physical plant, training of staff, adoption of sanitation and safety minimums, and provision of a safe and secure living environment. In offering specific guidelines for facility and program operations, the manuals of standards address due process and discipline, including access to the courts, mail and visitation, searches, and conditions of confinement of special management offenders.

The standards are systematically revised to keep pace with the evolution of different correctional practices, case law, and after careful examination of experiences, applying them over a period of time and circumstances. The ACA Standards Committee, which includes membership from the Commission on Accreditation for Corrections, is responsible for standards development and revision.

The ACA publishes biannual supplements to the standards with updated information and clarifications until new editions of standards manuals are published. Each supplement addresses standards interpretations, deletions, revisions, and additions for all manuals of standards issued by the Standards and Accreditation Department.

Suggestions and proposals for revisions to the standards from the field and interested others are encouraged. Performance Based Standards & Expected Practices Accreditation Department has developed an on-line process specifically for this purpose. Proposals should be submitted via the ACA website.

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Accreditation Process Descriptions

For over 120 years, the American Correctional Association has been the only national body involved in the development of standards for the correctional field. ACA standards are supported by ACA's Performance Based Standards & Expected Practices Accreditation Department and the Commission on Accreditation for Corrections, which is the evaluating and certifying body for accreditation. The department is responsible for the administration of accreditation and ongoing development of correctional standards.

The accreditation process is a voluntary program for all types of correctional agencies. For these agencies, accreditation offers the opportunity to evaluate their operations against national standards, to remedy deficiencies, and to upgrade the quality of programs and services. The recognized benefits of such a process include: improved management; a defense against lawsuits through documentation; demonstration of a "good faith" effort to improve conditions of confinement; increased accountability and enhanced public credibility for administrative and line staff; a safer and more humane environment for personnel and offenders; and the establishment of measurable criteria for upgrading programs, staffing, and physical plant on a continuous basis.

A major component of the accreditation process is the standards compliance audit conducted by a visiting committee. The purpose of the audit is to measure operations against the standards, based on documentation provided by the agency.

The Visiting Committee Report

The results of the standards compliance audit are contained in the visiting committee report, a document prepared by the visiting committee chairperson. The report is distributed to the agency administrator and members of the visiting committee. This report is also submitted to the Commission on Accreditation for Corrections for consideration at the accreditation hearing.

The following information is usually contained in the visiting committee report:

Agency and Audit Narrative

The agency narrative includes a description of program services, a description of physical plant, number of offenders served on the days of the audit, a summary significant incidents and consent decrees, class action lawsuits and/or judgments against the agency/facility, if applicable. The audit narrative, prepared by the visiting committee chairperson, describes audit activities and findings. The narrative examines issues or concerns that may affect the quality of life and services in an agency or facility. Quality of life issues include areas such as staff training, adequacy of medical service, sanitation, use of segregation and detention, reported and/or documented incidences of violence and crowding in institutions, offender activity levels, programming and provision of basic services. The audit narrative also contains comments as a result of staff and offender interviews, and a detailed explanation of all noncompliant and not applicable standards.

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Agency Response

The agency has three options for standards found in noncompliance: a plan of action; an appeal; or a waiver request.

A **plan of action** is a detailed statement of tasks to be performed in order to achieve compliance with a standard found in noncompliance at the time of the audit. The plan of action designates staff responsibilities and timetables for completion.

An **appeal** is the agency's attempt to change the visiting committee's decision on a standard. The result of a successful appeal is a change in the status of the standard and a recalculation of the compliance tally.

A **waiver** may be requested when noncompliance with a standard does not adversely affect the life, health, or safety of staff and offenders and when quality of life conditions compensate for the lack of implementation of a plan of action. The granting of a waiver by the Commission waives the requirement for submitting a plan of action; however, it does not change the noncompliant finding.

Auditor's Response

This section contains the visiting committee's final reply to all responses received from the agency and includes comments regarding the acceptability of plans of action, appeals, and waivers.

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AccreditationHearings

The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers an agency's application at its next regular meeting following completion of the visiting committee report. The Commission is divided into panels that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include a quorum of at least three Commissioners which includes the panel hearing chairperson. Agencies are notified in writing of the date, time, and location of the hearings by Performance Based Standards & Expected Practices & Accreditation Department Staff.

The panel hearing is the last step in the process. With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented during the hearing and in the visiting committee report is considered by the panel members in rendering accreditation decisions.

The agency is invited to have a representative at the hearing and, in most cases, one or more individuals attend. When special conditions warrant, the visiting committee chairperson or a member of the visiting committee also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) occurs only with the permission of the applicant agency. In these cases, the applicant agency representatives and panel members discuss procedures to be followed before commencement of the hearing.

Conduct of Hearings

The panel schedule provides ample time for review of each individual agency pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures. Panel proceedings require that a formal vote be taken on all final actions, i.e., agency appeals, waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- Applicant agency representatives are requested by Standards and Accreditation Department staff to be on-call to allow for scheduling flexibility.
- A designated waiting area is usually provided for this purpose.
- When the panel is ready to review the agency, the Standards and Accreditation Department staff representative notifies agency representative(s).
- The hearing opens with an introduction by the panel chairperson. The agency representative is asked to give a brief description of the program.

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- If a visiting committee member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the visiting committee member only to request additional information at different points during the hearing.

- The panel chairperson leads a standard by standard review of non- compliance issues. The agency representative presents information relative to their request for waivers, plans of action, appeals, and discretionary compliance requests. The agency may also present additional materials, including photographs or documentation, for review by the panel.

- Following the agency presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of agency personnel or in executive session varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

In final deliberations, the Commission panel:

- Ensures compliance with all mandatory standards and at least 90 percent of all other standards.

- Responds with a formal vote to all appeals submitted by the applicant agency.

- Responds with a formal vote to all request for waivers and plans of action submitted by the applicant agency.

At this time, the panel also:

- Assures that an acceptable plan of action will be submitted for every non- compliant standard, including those standards for which appeals of non- compliance and waiver requests have been denied by the panel. In judging the acceptability of plans of action, the panel ensures that all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.

- Addresses to its satisfaction any concerns it has with visiting committee comments about the quality of life in the facility or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to the life, health, and safety of residents and staff.

- For each application, a roll call vote to award accreditation, extend an agency in Candidate or Correspondent Status, or deny accreditation is conducted. The options for final action available to the panel are outlined in the next chapter.

- If the panel has deliberated in executive session, agency representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant. If accreditation has not been granted, the chairperson discusses with agency personnel specific reasons for the decision and the conditions of extension in Candidate or Correspondent Status and procedures for appeal.

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Accreditation Decisions

Three decisions relative to the accreditation of an agency are available to panels:

- *Three-year accreditation award* based on sufficient compliance with standards, acceptance of adequate plans of action for all non-compliant standards and satisfaction of any other life, health, and safety conditions established by the panel. The balance of the contract must be paid in full in order to receive a certificate of accreditation.

- *Extension of the applicant agency in Candidate Status* (initial accreditation only) for reasons of insufficient standards compliance, inadequate plans of action, or failure to meet other requirements as determined by the panel. The Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the facility or program that adversely affect the life, health, or safety of the offenders or staff. Extension of an applicant in Candidate Status is for period of time specified by the panel and for identified deficiencies if in the panel's judgment, the agency is actively pursuing compliance.

- *Probationary Status* is determined when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are quality of life issues that would indicate continued monitoring. While an award of accreditation is granted, a monitoring visit must be completed and the report presented at the next meeting of the Commission. The cost for a monitoring visit is borne by the agency at a rate of cost plus 25%. The agency does not have to appear before the Commission for the review of the monitoring visit report. If they choose to do so, all related travel expenses are borne by the agency. Specific expectations for removal from probation are outlined.

- *Denial of accreditation* removes the agency from Accredited Status (in the case of reaccreditation) and withdraws the agency from the accreditation program. Situations such as insufficient standards compliance, inadequate plans of action, failure to meet other requirements as determined by the panel or quality of life issues may lead to the denial of accreditation, it is withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing. The Commission will explain the process for appeal.

The agency receives written notification of all decisions relative to accreditation after the hearing.

Appeal Process

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status, or placement into probationary status. Therefore, if an agency is denied accreditation, it is immediately appealed to the full commission.

If an agency is put in probationary status by the panel, it may submit an appeal of the placement into probationary status. The basis for reconsideration of probationary status is based on grounds that the decision(s) were:

- A misinterpretation of the criteria and/or procedures promulgated by the Commission

- Based on incorrect facts or an incorrect interpretation of facts

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- Unsupported by substantial evidence
- Based on information that is no longer accurate
- The reasonableness of the expected practices, criteria, and/or procedures for the process may not serve as the basis for reconsideration.

The procedures for reconsideration are as follows:

- The agency can submit a verbal appeal immediately to the Performance Based Standards & Expected Practices & Accreditation or a written request for reconsideration within 30 days of the adverse decision stating the basis for the request.
- The Executive Committee of the Commission, composed of the officers of the Commission, reviews the request and decides whether or not the agency's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The agency is notified in writing of the Executive Committee's decision.
- If the decision is made to conduct a hearing, the hearing is scheduled for as soon as possible if the appeal is made verbally or if in writing, for the next full Commission meeting and the agency is notified of the date.
- The agency, at its option and expense, has the right of representation, including counsel.
- Following the hearing held before the Commission, the decision, reflecting a majority opinion, is made known to the agency immediately.
- Pending completion of the reconsideration process, the agency maintains its prior status.
- Until a final decision has been reached, all public statements concerning the agency's accredited status are withheld.

Following completion of the reconsideration process, any change in the status of an agency is reflected in the next regularly published list of accredited agencies.

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Accredited Status

The accreditation period is three years, during which time the agency must maintain the level of compliance achieved during the audit and work towards compliance of those expected practices found in non-compliance. Regular contact with Performance Based Standards & Expected Practices & Accreditation Department staff should also be maintained. The Annual Report, Critical Incident Report and Significant Incident Summary forms discussed below are available on the ACA website at www.aca.org or through your Accreditation Specialist.

Annual Report

During the three year accreditation period, the agency submits an annual report to the Performance Based Standards & Expected Practices &Accreditation Department. This statement is due on the anniversary of the accreditation (panel hearing) date utilizing the annual report form, which is available on the ACA website or from Performance Based Standards & Expected Practices & Accreditation Department staff. It contains the following information:

Current compliance levels - This includes any changes in compliance since accreditation, listing on a case by case basis any expected practice with which the agency has fallen out of compliance or achieved compliance.

Update of Plans of Action - A progress report is included with respect to Plans of Action submitted to the hearing panel, indicating the status of the completion of the plans. Potential revision to plans reflecting the need to request additional time, funds, and/or resources to achieve compliance should also be included.

Significant Incident Report Summary - A report is made of events and occurrences at the agency during the preceding year that impact on compliance, agency operation, or the quality of services provided by the agency.

Performance Based Standards & Expected Practices & Accreditation Department staff review the annual report received from the agency and respond to clarify issues or request additional information if necessary.

Critical Incident Report

In addition to submission of the annual report, the agency is responsible for notifying Performance Based Standards & Expected Practices & Accreditation Department staff of any critical incident that has the potential to affect expected practice compliance or facility accreditation as soon as possible within the context of the incident itself, using the Critical Incident Report template on the ACA website or through Performance Based Standards & Expected Practices Accreditation Department staff.

Monitoring Visits

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) in order to assess continuing compliance with the standards. A monitoring visit may be conducted at any time during the accreditation period, with advance notice to the agency. The determination of need for a monitoring visit is based on:

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- Compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing.

- Incidents or events reported by the agency in its annual report.

- Problems indicated by adverse media reports or correspondence received by Performance Based Standards & Expected Practices & Accreditation Department staff, disturbances at the agency, or special investigations.

The length of the visit varies depending on the number of standards or special issues that must be addressed during the visit. The visits are conducted similar to standards compliance audits, but on a reduced scale. Monitoring visits are charged to the agency at a rate of cost plus twenty-five percent.

Activities, as a general rule, involve a review of all mandatory standards, all standards found in non-compliance at the time of accreditation, and any other concerns identified by the Commission. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit. The report includes a list of standards reviewed, explanation of non-compliance findings, results of the tour and interviews with agency staff and offenders, and discussion of any issues believed to be relevant to the agency's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the agency by Performance Based Standards & Expected Practices Accreditation Department staff.

When a monitoring visit to the agency reveals deficiencies in maintaining compliance levels that existed at the time of accreditation, or less than 100 percent compliance with mandatory standards, the agency prepares a response providing explanation of the problems indicated in the report. When the agency has failed to maintain compliance with all mandatory standards, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections for review during a regular hearing. Agency representatives are advised of the date, time, and location of the review, and are invited to attend. At the discretion of the Commission, the agency may be placed in probationary status and a revisit conducted to determine if deficiencies have been corrected.

Revocation of Accreditation

If the Commission panel believes that an agency's failure to maintain continuous compliance with certain standards is detrimental to life, health, and safety of residents and staff, the Commission may place an agency on probation. Probationary status last for a specific period of time designated by the Commission at its next regularly schedule meeting. The Commission again reviews the program and considers removing the probationary status or revoking accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted, the agency resumes its status as an accredited agency. An agency that does not satisfactorily correct the deficiencies may be withdrawn from accreditation.

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Another condition that may result in a rehearing and consideration of revocation is following a significant event in an agency (i.e. major disturbance, death from other than natural causes or allegations of physical/sexual abuse of offenders). Failure to notify the Performance Based Standards & Expected Practices & Accreditation in a timely manner may result in suspension of the agency's accreditation. Once ACA is notified of the major event, the Director of Standards and Accreditation may consult with the Executive Committee of the Commission, who may request a monitoring visit. If a visit is warranted, ACA will notify the agency and a date will be established with the concurrence of the facility. The monitoring visit will take place within 14 days of this notification. The monitoring visit report will be sent to the Director of Standards within 7 days of the monitoring visit and then forwarded to the Executive Committee of the Commission. Following review of the report, a determination will be made by the Executive Committee as to whether revocation of accreditation is warranted. Prior to any rehearing, agency representatives will be notified, so that any issues may be addressed and responded to in writing.

Accreditation is revoked for the following reasons:

- Failure on the part of the agency to adhere to the provisions on the contract.
- Failure on the part of the agency to maintain continuous compliance with the standards at levels sufficient for accreditation.
- Intentional misrepresentation of facts, lack of good faith, or lack of deliberate speed or a concerted effort to progress in the accreditation process, including the implementation of plans of action.
- Failure to notify ACA of significant incidents in the annual report to the Commission.
- Adverse conditions of confinement that affect the life health, and/or safety of staff and offenders.
- Failure to comply with the conditions of probation or suspension.

Performance Based Standards & Expected Practices & Accreditation Department staff notify the agency in writing of the specific reasons identified by the Commission for the revocation hearing.

Expiration of Accredited Status

Accreditation is granted for a three year period. Unless the agency has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the agency from Accreditation Status after this three year period.

For agencies in Accredited Status that are seeking subsequent accreditation, administrative extensions of Accredited Status may be granted under certain conditions. For example, relocation of the facility, staff turnover, and major renovations often warrant an extension. In these cases, a written request to the Director of Performance Based Standards & Expected Practices & Accreditation is required, outlining the reasons for extending the accreditation period. Agencies that fail to successfully complete an audit within the three year period, or do not receive an extension prior to their expiration date, are withdrawn from Accredited Status.

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Visiting Committee Report and Hearing Minutes

CONFIDENTIALITY

The American Correctional Association and the Commission on Accreditation for Corrections do not disclose to external parties specific information contained in this Accreditation Report or information discussed in the Accreditation Hearing. The Association encourages all participating agencies to provide information to the media about their accreditation activities, including disclosure of the Self-Evaluation and Accreditation Report.

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE INITIAL AUDIT

ICE Health Service Corps (IHSC)
Eloy Detention Center (IHSC)
Eloy, Arizona

March 12-13, 2018

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C), Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The audit of the Eloy Detention Center (IHSC), Eloy, Arizona was conducted on March 12-13, 2018 utilizing the American Correctional Association (ACA) Standards for Performance Based, Health Care for Adult Local Detention Facilities, 4th Edition and the 2016 Standards Supplement. The following team conducted the audit: (b)(6); (b)(7)(C) Chairperson and (b)(6); (b)(7)(C) Team Member. This is an initial audit because the facility is using a new accreditation manual for the PB,HCALDF. Eloy Detention Center (IHSC) was previously accredited using the PB,HCACI accreditation manual in 2015.

B. Facility Demographics

Rated Capacity: 1,484 (Males – 1,000 and Females - 484)
Actual Population: 1,484 (Males – 1,000 and Females - 484) as of 03/12/2018
Average Daily Population for the last 12 months: 1,383
Average Length of Stay: 51 days

(b)(7)(E)

Age Range of Detainees: 18-75+
Gender: Male/Female

(b)(7)(E)

C. Facility Description

The Eloy Detention Center-IHSC (EDC-IHSC) provides detention services, housing, and transportation for detainees who are in administrative custody of the Immigration and Customs Enforcement (ICE). Detainees at the EDC-IHSC are either awaiting deportation or are currently in the removal proceedings. The EDC-IHSC is privately owned and operated by the CoreCivic, formerly the Corrections Corporation of America (CCA) under a contract with the Department of Homeland Security. Medical services are provided by the Immigration Health Service Corporation (IHSC). The facility houses individuals, both male and female, who are pending immigration review. The facility mission is to protect the public, staff and provide a secure and humane environment for all detainees.

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EDC-IHSC is situated on 47 acres of land approximately seven miles from the city of Eloy in Pinal County, Arizona. The facility is physically located at 1705 East Hanna Road, Eloy, Arizona 85131.

Eloy Detention Center (EDC) opened in May of 1994, and was the Federal Bureau of Prisons' first contract for a secure facility with a private company. EDC is a 1,484-bed facility. The male and female detainees are housed in six housing units and two special housing units. The Administration Building and General Service Building separate the general housing units and one special housing unit into two separate sides; north and south. The general housing units hold 250 detainees in five pods. (b)(7)(E) (b)(7)(E) There are currently two pods containing female detainees. Special Housing Units are divided into two 24-bed units separated by an officer station. The institution also has four court rooms used for deportation hearings. Each month an average of 592 detainees are admitted, 587 are released and 97 medical transports. This 392,000 square foot facility contains state-of-the-art safety and security equipment, (b)(7)(E) (b)(7)(E)

(b)(7)(E)

ICE Health Services Corps Vision Statement: To be the best health care delivery system in detention and correctional health care

ICE Health Services Corps Mission Statement -"IHSC is committed to providing health care services to reduce global disease and support the safe apprehension, enforcement and removal of detained individuals involved in immigration proceedings".

ICE Health Services Corps Core Values: Integrity, Commitment, Accountability, Service and Excellence.

Eloy Detention Center first achieved American Correctional Association dual accreditation (ACI & ALDF) in August of 2003 and has continued to remain accredited since that time. The facility received the nation's first Department of Homeland Security Federal PREA certification in 2017.

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Other accreditation for the EDC-IHSC includes National Commission on Correctional Health Care (NCCHC), 10/2015 and Performance Based National Detention Standards (PBNDS), 2/2018 (ICE).

Eloy is adjacent to three other prisons also managed by the CoreCivic: the Red Rock Correctional Center, the La Palma Correctional Facility and the Saguaro Correctional Center.

(b)(7)(E)

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D. Pre-Audit Meeting

On Sunday, March 11, 2018 the members of the medical audit team were transported from the Phoenix Sky Harbor International Airport, Phoenix, Arizona to the Holiday Inn Casa Grande, Casa Grande, Arizona by Warden Michael Donahue for (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Team Member. The distance from the airport to the hotel was approximately 53.6 miles.

The audit team met at the hotel on that evening to discuss the information provided by the Association staff and the officials from the Eloy Detention Center (IHSC).

The chairperson divided the standards into the following groups:

Standards #4-ALDF-2A-45 to 4C-40 to (b)(6); (b)(7)(C)
Standards #4-ALDF-4D-02 to 4D-27 to

The audit team members attended an "ice-breaker" dinner at the Eva's Mexican Restaurant that Sunday approximately from 5:00 p.m. to 6:30 p.m. that evening with the following CoreCivic employees: Warden Michael Donahue, (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) General conversation followed as the team member and the facility staff became acquainted, and general audit goals and procedures for the audit were discussed.

E. The Audit Process

1. Transportation

On Monday, March 12, 2018, the audit team was picked up from the hotel by Warden Michael Donahue at 5:50 a.m. and arriving EDC at 6:15 a.m. The team followed the EDC's security procedures and was escorted to the facility by Warden Michael Donahue for a brief housekeeping meeting with the Health Services Administrator (HSA) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) The team expressed the appreciation of the Association for the opportunity to be involved with Eloy Detention Center in the accreditation process. The meeting lasted from 6:15 a.m. to 6:30 a.m. The team visited the night shift and observed the shift change from 6:30 a.m. to 7:25 a.m.

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2. Entrance Interview

At 7:30 a.m. the same day, the audit team proceeded with the formal entrance meeting at the IHSC break room. The audit schedule and procedures were discussed, and the staffs were asked about any problem areas of which the teams should be aware. The staffs were advised that the audit team would meet with them each evening prior to their departure from the facility to discuss the progress of the audit up to that point, and any problems that were encountered, and the audit team will attempt to review all the mandatory standards on the first day. Escorts were requested to accompany the auditors on the tour and subsequent visits to departments, and to note the number of detainees and the names and titles of employees with whom the auditors spoke. The staffs were asked if any detainee or employee had requested to speak with the auditors. No requests had been made.

The audit chairperson expressed the team's appreciation and the appreciation of the American Correctional Association for the opportunity to be involved with the audits in its initial-accreditation process, and emphasized the goals of the accreditation, which are to improve the efficiency and effectiveness of correctional systems throughout the United States. The chairperson explained the reason for the initial vs. re-accreditation audit. The audit teams were aware that the staff had worked long and hard in preparation for this event, and accordingly the teams would endeavor to provide a fair, equitable and thorough audit as possible while holding them accountable to high standards. The team members would visit as many departments and areas as possible relating to the audit and meet and speak with as many staffs and detainees as possible in the time available, while at the same time strive to be as non-intrusive as possible. It was requested that when audit team members paused to speak with detainees, that staff step away so that the conversation may remain private and the team would like to observe the practice in any medical emergency. The audit team reemphasized that the purpose of the audit is to be helpful and to assist the facility in achieving its initial-accreditation. The entrance meeting lasted until 7:40 a.m.

The following persons were in attendance:

Chief Medical Officer
Health Services Administrator
Health Services Administrator

Assistant Health Services Administrator
Nurse Manager
Program Manager
Registered Nurse
Medical Director
Physician Assistant
Nurse Practitioner

(b)(6); (b)(7)(C)

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Nurse Practitioner	(b)(6); (b)(7)(C)
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Registered Nurse	
Licensed Practical Nurse	
Licensed Practical Nurse	
Licensed Clinical Social Worker	
Medical Records Technician	

3. Facility Tour

The audit team toured the medical area and other areas relating to the IHSC audit from 7:45 a.m. to 9:15 a.m. ACA audit notices were posted throughout the facility (English and Spanish). Staff and detainees were aware that an audit was taking place. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

Warden	Michael Donahue
Assistant Warden	(b)(6); (b)(7)(C)
Assistant Chief of Security	
Health Services Administrator	
Assistant Health Services Administrator	
Nurse Manager	
Program Manager	
Registered Nurse	

The following areas of the institution were visited and the following personnel and detainees were encountered during the course of the tour:

Immigration and Custom Enforcement	(b)(6); (b)(7)(C)
CoreCivic	
Security	
ICE Health Service Corps (IHSC)	
Echo Unit	

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Bravo Unit

Laundry
North Intake

Pharmacy

Dental

(b)(6); (b)(7)(C)

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life. The facility noise levels are within reason. There was no offensive order or smell of fresh paint. There was no evidence of pest or rodent infestation or complaint. All areas of the facility are clean and well maintained. Chemicals are properly stored and well controlled; SDS sheets are available. Tools are on shadow boards and appropriately stored and inventoried. The housing units are clean with the detainee living areas neat and organized. There is a large outdoor exercise area with a soccer field, fixed weights, and basketball hoops. Each housing unit has a day room equipped with a television, board games, puzzles and a microwave. The housing units were quiet and there appeared to be a very low level of tension in the units.

Security:

(b)(7)(E)

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Environmental conditions:

Temperature, airflow and lighting are kept at comfortable levels throughout all areas medical and the facility. The noise levels were low. The audit team did not observe any shouting, banging on doors, offensive smell or smell of paint. The audit team interviewed several detainees on overall environmental welfare and condition inside the facility and they were complimentary.

Sanitation:

Sanitation is provided using detainees and staff assistance. The medical areas were remarkably clean with all cleaning materials kept in clean rooms with no caustic or toxic chemicals present.

Cleaning solutions were all distributed from a central location where they are properly diluted before distribution. The master SDS of all chemicals are kept in the main clinic and updated accordingly.

Food Service:

Food Service is provided by staff working for Trinity Services Group. The food service area is clean. The area is inspected weekly by food service staff, monthly by the safety officer and annually be the health department. A five weeks menu cycle, approved annually by a Registered Dietitian, is utilized and based on three hot meals per day. A diet for health, hyper calorie diet, renal diet, vegetarian and texture modifications are available.

There are two dining halls (north and south) 250 each capacity. The audit team observed trays and sampled one lunch meal of Jello, mix vegetable, marsh potato with gravy, two slices of wheat bread, baked chicken, butter, salt and pepper and a choice of Kool-Aid drink or water on the first day of the audit. The meal was nutritionally adequate, palatable and temperature tested. There are no pork products served.

Medical diets are provided by the food service department upon receipt of written instructions from the facility Clinical Director. Meal samples are kept for 72 hours. At the time of the audit, there were 10 medical diets. These diet orders contain both start and stop dates. These may be ordered anywhere from one day to length of stay. Pregnant detainees receive special diets and extra snacks. Medical evaluations and screenings are done on detainee workers which monitored cuts/sores, burns, runny nose, nail condition and cold/flu symptoms.

Refrigerators, freezers and the dry storage area are clean, orderly and clutter-free, and temperatures are in the appropriate ranges. The dishwasher was in proper working order, and documentation reflected temperatures in the appropriate range.

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Medical Care

Medical services at the Eloy Detention Center-IHSC (EDC-IHSC)) are contracted through the INGENESIS. They also utilize Public Health Service (PHS), part-time and as needed contracted staffing. They provide medical, mental health and dental services. EDC medical receives transfers and in-transit, border patrol and intra and inter system transfer detainees and some with the history of high-risk behaviors, compounded by lack of medical care and or mental health treatment, and are more likely to have chronic illnesses and infectious diseases. The facility has a responsible physician (MD) and a Health Services Administrator (HSA). The working relationship between medical, mental health, program, dental and security are very remarkable. Medical staffs are well trained and caring professionals. The team interviewed several detainees and they were complimentary of medical services. Telemedicine is not practiced at the EDC-IHSC. The audit observed an intake process from the border patrol on the first day of the audit, and medical responded accordingly.

EDC-IHSC clinic operates (b)(7)(E) (b)(7)(E) (Sunday-Saturday). The Public Health Service staffs are on call. Schedules allows for shift briefings.

The following fulltime staffs support the IHSC clinic: (b)(7)(E) (b)(7)(E)

EDC-IHSC medical clinic has the followings:

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- 2 AEDs (secured and inspected)
- 1 EKG (secured and inspected, and read on site)
- 1 Fixed digital chest x-ray machine
- 2 Emergency bags (secured, inspected and sealed)
- 2 Emergency stretcher with straps (secured and inspected)
- 2 Dedicated emergency medical vehicle-gulf carts (1-north and 1-south)
- 2 Transport gurneys (secured and inspected)
- 1 Secure medication room
- 1 Medication administration room
- 2 Pill windows (1-North and 1-South)
- 3 Refrigerators -Flu, TB Solutions, etc.(1-Pharmacy, 1-Lab and 1-Medline)
- 1 Refrigerator (Specimen)
- 2 Portable oxygen cylinders (secured and inspected by AirGas)
- 2 Negative pressure rooms (cameras, toilets and sinks, and last inspected 10/23/2017)
- 8 Suicide observation rooms (cameras, toilets and sinks)

EDC-IHSC is an ADA compliant facility and has an ADA Coordinator.
It complies with the Disability Placement Program (DPP) that provides for housing accessible lockers, bunk beds with grabs bars, accessible TTY phones, volume control phones, accessible dayroom tables and accessible path of travel. There are ample supplies of walking sticks, crutches and wheel chairs in the facility.

EDC-IHSC clinic uses the following hospitals for inpatient hospitalization:

1. Banner Casa Grande Medical Center, Casa Grande, Arizona (ER)
2. Maricopa Medical Center, Phoenix, Arizona (ER)
3. Promise Hospital, Phoenix, Arizona (Infirmary Service)
4. St. Mary's Hospital, Tucson, Arizona

EDC-IHSC has an agreement with the Eloy and Florence Fire Department (11-22 miles, 7-10 minutes) for ambulance services in case of medical emergencies. Non-emergent medical transportation is done by facility staff to either a hospital facility or community provider for offsite consultations. The nurses have Basic Life Support (BLS) certified through the American Heart Association (AHA). Medical maintain basic TTA protocol medicines. The Master SDS is maintained in medical. Officers are trained on first aid, CPR and AED, and are considered first responders. Upon admittance to the EDC-IHSC, detainees receive a detainee handbook to aid in adjustment to detention setting. This documentation contains information regarding medical services, sick call process, grievance procedures and hygiene rules. Other methods are used to inform detainees about MRSA, AIDS, Hepatitis, and the spread of HIV, blood borne pathogens and safety.
There is a language line translation and video orientation in English, Spanish, Mandarin, Chinese, and Punjabi at the time of the audit.

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Sick call is provided seven days a week in General Population (GP) from 5:00 a.m.to 7:00 p.m. and Segregation (SEG) at 7:45 a.m. to 9:00 a.m. (cell side) and as needed. Detainees sign up for sick calls at each housing unit between the hours of 5:00 a.m. and 06:00 a.m. Detainees housed in SEG access all medical services via face to face encounters with an RN during daily rounds. Detainees housed in GP access all medical services via call out logs. The average monthly sick calls are 974. The audit team observed sick call process in GP and SEG on the second day of the audit and found the process well organized. Medical requests are triaged within one to two days, and any patient with symptoms is seen within one day. There is no medical copay. No detainee is denied health care service. EDC-IHSC uses detainee electronic medical records. Medical grievance is through the grievance box, collected by a grievance coordinator, and reviewed by the HSA within two days. EDC-IHSC averages 1-2 substantiated medical grievances per year mostly on medication preference, medication refills, comfort items and time line to see a provider. Specialty services/consults are provided through off-site contracted specialists. The turnaround time is 48-72 hours depending on medical acuity and specialty.

Optometry service is contracted through the South Western Eye Clinic. There were fourteen pregnant detainees at the time of the audit on March 12, 2018. All pregnant females are referred to an offsite OB-GYN specialist. The number of chronic care detainees excluding mental health at the time of the audit was 159.

EDC-IHSC has a plan for the management of communicable diseases including education on prevention, diagnosis, treatment and isolation. EDC-IHSC has an infectious disease coordinator. EDC-IHSC has two single-bed negative pressure rooms with last inspection date of October 23, 2017 by the Air Management Solutions, Powder Springs, GA. Infirmary service is provided through the Promise Hospital, Phoenix, Arizona. MRSA precautions are in place. Universal precautions are practiced throughout the facility. There are available first aid and blood borne pathogen kits. There are eye wash stations present in appropriate areas. Hand sanitizers (non-alcohol) dispensers were located throughout medical and other areas. Sanitation and housekeeping is provided by detainees. The total monthly TB tests are seven. An annual TB screening is conducted on all detainees after 12 months. EDC-IHSC offers limited TB sticks, mostly chest x-rays on site.

Medications are stored in medication rooms and secured behind double locks. A nurse administers medications including diabetic lines four times a day and seven days a week in GP and SEG at 5:00 a.m., 10:00 a.m., 4:00 p.m., 7:00 p.m. and as needed. Prior to giving medications, detainee's identification is confirmed and mouth cavities checked after administration. The audit team observed medication administrations in the GP and SEG on the second day of the audit and found the process organized and timely. All no shows or refusal to medications are documented and /or referred.

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The HSA checks the MARS paper record for missed doses. The audit team examined the manual during the audit and found it current. There are ten medical diets, including 50 diabetics (26-insulin and 24-non insulin dependents) at the time of the audit. Some insulin dependent diabetics receive midnight snacks. Health care outcome measures show better management of hypertension and A1C levels. The average monthly detainees on prescription medications are 2824 (including multiple encounters), and controlled medications are 17. Some medications are crushed per doctor's order. Detainees are provided script medications upon release depending on illness; 14 days-normal, 30 days-TB/HIV. Specific over-the-counter (OTC) medications are offered at the Commissary, and reviewed and approved by the Clinical Director (MD).

IHSC clinic has a dispensary, and supported by (b)(7)(E)

(b)(7)(E)

A random inventory count on sharps and controlled medications was accurate. The pharmacy has a refrigerator for the storage of insulin, vaccines and ice packs.

The audit team found the temperature log and inventory current. Basic medical supplies and materials are obtained through McKesson. The disposal of expired, unused, discontinued, recalled, over stocked medications including prescription, (pills and liquids) and narcotics are arranged through the Reverse Distributor-Pharma logistics. At the time of the audit there were some medications awaiting disposal. Records are maintained on disposal process. The audit team recommended the addition of the Rx Destroyer or the Stryker's Cactus Smart Sink System as part of control medications and narcotic disposals process, and to ensure that all patient specific medications have filled date, original Rx date and expiration date.

EDC-IHSC medical has a draw only lab. Specimens are collected on site. Blood is spun and sent out for analysis to the LabCorp five days a week, including STAT labs and reports received through fax/phone within 24-48 hours. Average monthly detainee lab tests are 1104. Stericycle is contracted to pick up the biohazard and sharps wastes. The audit team checked the specimen refrigerator temperature log and found the records current. Chronic care patients receive annual screening test. Laboratory results are also incorporated into the EMR. Digital radiology is used in the facility with hard copy over-reads scanned into the electronic health record (EMR).

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IHSC clinic has a fixed wall stand digital chest x-ray machine. (b)(7)(E) (b)(7)(E) Radiology services (MRI, Ultrasound, etc.), including STATS are provided through the Banner Casa Grande General Hospital and AZ-Tech with results received within hours by phone/fax depending on urgency.

EDC-IHSC performs detoxification from alcohol, opiates hypnotics, other stimulants and sedative hypnotic drugs. Substance abuse treatment is provided, as are a large number of behavioral health groups and classes. All detainees enrolled and participating in these groups had individual treatment plans in place. There are regularly scheduled multi-disciplinary team meetings, including medication management when appropriate and necessary.

(b)(7)(E)

(b)(7)(E) Dental services are provided from 06:30 a.m.to 02:30 p.m. (Monday-Friday). The dentist visits Tuesday and Thursday. Dental services include basic dentistry, fillings, partials, root canal, extractions, cleaning, oral cancer screenings and patient education. The detainees access dental health services through the sick call log process. The audit team reviewed the licenses, registrations, records and random inventory of sharps and instruments and found them accurate. The dental area is clean. Dental instruments and sharps not used at the year of expiration are re-autoclaved and repackaged. Dental spore test is through Crosstex.

The Dentist has a standing order; dental emergency outside the expertise of the nurse is referred to one of the contracted hospitals. Dental at EDC-IHSC is equipped with one dental bitewing digital x-ray machine, two dental chairs and one Panorex digital x-ray machine. The dental wait time is less than seven days. Urgent requests are seen within 24 hrs. The average monthly dental appointment is 124.

Dental amalgam disposal is through the Wastewise. Dosimeter reading is through Landauer Dosimetry. Dental chair traps are cleaned weekly. Dental supplies are through the Henry Schein and dental equipment services are through the A-Tech.

(b)(7)(E)

(b)(7)(E) They provide services from 7:00 a.m. to 7:30 p.m. (Sunday-Saturday) and on call. Daily rounds are conducted. Detainees access mental health services via the sick call log process. Staffs can refer services. There are approximately 372 detainees seen monthly. All suicide ideations are referred to mental health and monitored, and are observed 1:1. Mental health utilizes the eight single-bed isolation rooms. There are available suicide smocks and blankets. Tele-psychiatry is practiced at EDC-IHSC. EDC-IHSC maintains zero tolerance for sexual abuse and harassment.

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Detainees are provided information on enhanced victim services and rape crisis hotline. Rounds are done daily and are evaluated every 30, 60 or 90 days depending on needs. Program services include crisis intervention, individual and group counseling and medication management. EDC-IHSC has no therapeutic community program and does not house severely developmentally and disabled detainees. EDC-IHSC utilizes the following mental health hospitals:

1. Desert Vista Behavioral Health, Mesa, Arizona
2. Cornerstone Behavioral Health – El Dorado, Tucson, Arizona
3. Sonora Behavioral Health Hospital, Tucson, Arizona
4. Alvarado Parkway Institute Behavioral Health System Outpatient Services, San Diego, California

There were approximately 76 detainees on psychotropic medication at the time of the audit.

Laundry:

The Laundry operates four Commercial Washing Machines with an automatic detergent feed and four dryers in a clean facility. Detainees exchange clothing twice per week and linens once per week. Undergarments are exchanged daily. Staff employees wash the detainees' personal clothing.

F. Examination of Records

Following the facility tour, the team proceeded to a medical private office to review the accreditation paper files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

   The facility had no consent decrees, class action lawsuits or adverse judgments in the past year according to records.

2. Significant Incidents/Health Care Outcome Measures

   The Significant Incident Summary and the health care section of the Outcome Measure were reviewed with the Health Care Administrative Team. During the audit period, the number of detainee-on-detainee assaults was 32 and detainee-on-staff assault is 18. While the numbers are noteworthy and will impact health care services, it was determined that it was within the appropriate range that would be expected for an institution of this size, population, custody level and mission. There was discussion regarding the following sections on the outcomes measures for the audit period:

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Section 4C (8) Number of offenders with an individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time was 116, and the average daily population in the past 12 months of the audit period was 1375. The EDC-IHSC provided statement that the facility receives intake from the Border Patrol and has younger population with diverse cultural background and sometimes with an adjustment problem.
Section 4C (9) Number of inmate suicide attempts in the past 12 months was 4, and the average daily population in the past 12 months of the audit period was 1375. EDC-IHSC medical is monitoring the matter and coordinating activities with the mental health.

Section 4C (33) Number of pharmacy dispensing errors in the past 12 months was 2, and the number of prescriptions dispensed by the pharmacy in the past 12 months of the audit period was 23876. The EDC-IHSC provided statement that patient received medication not ordered due to pharmacy adding the wrong prescription label to the wrong Medication Administration Record (MAR). There was no adverse reaction to the patient. The other incident includes the Pharmacist filling wrong dosage/strength of prescribed medication which patient received. Process study was completed: Staff Pharmacist received additional training/counselling regarding pharmacy MAR process, with an emphasis on ensuring only the pharmacist can place new patient labels on MAR. There have been no further repeat incidences since this corrective action was put in place.

Section 4C (34) Number of nursing medication administration errors in the past 12 months was 34, and the number of medications administered in the past 12 months of the audit period was 3996. The EDC-IHSC provided statement that the errors were predominantly due to failure to follow medication verification process, where medications were not being verified by nursing staff once received from pharmacy by nurses. Process study (started July 2017) was completed: Nursing staff received additional training in regards to medication verification process as well as individual counselling was given to nurses identified to have the trend of not verifying medications on their shift upon receipt of medications and MAR. There was 100% compliance of medication verification by December 2017. Another trend that contributed to medication errors was constant distraction to pill line nurses during pill line hours in regards to patient medication. Staff training was completed with focus on reducing distraction during pill line hours; "Do Not Disturb during pill line hours" was also implemented and posted on the Pill Line door.

3. Departmental Visits

The team revisited the following departments to review conditions relating to departmental policy and operations:

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Department Visited	Person(s) Contacted
Food Service	(b)(6); (b)(7)(C)
Medical	
Security	
ICE	

4. Shifts

a. Day and Night Shifts

The team was present at the facility from 6:30 a.m. to 4:30 p.m. on the first day of the audit. The team observed shift briefing at 7:00 a.m. The briefing was mutual and participatory. The team briefly introduced themselves and discussed the purpose of the audit and matters pertaining to the audit.

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The team observed medication administration while the rest of the medical staff was busy taking care of the detainees and are pleasant and professional. (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

5. Status of Previously Non-compliant Standards/Plans of Action

There were no standards previously found non-compliant.

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

The audit team interviewed and spoke to approximately 89 detainees (68-males and 21-females); including eight pregnant females who stated that they generally felt secure at the facility and were treated fairly by staff. Their basic needs were being met and they felt that they were making positive progress towards eventual and successful release. They also felt that their basic medical needs were being met. They have ready access to sick call process and all were aware of the grievance process.

Detainee morale appeared to be good and they were cooperative, respectful and were aware of the audit, and participated in the preparation for the audit. Notices of the ACA Accreditation process were observed to have been posted at different locations readily available to the detainees.

2. Staff Interviews

The audit team interviewed and spoke to approximately 65 employees and observed them in the performance of their duties. The audit team observed structured medical shift change briefings. Staffs were polite, cooperative, and conducted themselves in a professional manner. There was a normal working relationship between medical, dental, mental health, programs and security, and communication flowed freely. Gender and ethnic diversity was good and morale also appeared to be good. Staff indicated that their training were excellent and are applicable to their positions and job needs.

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H. Exit Discussion

The exit interview was held at 11:45 a.m. in the facility conference room with Capt. (b)(6); (b)(7)(C) Chief Medical Officer, CDR (b)(6); (b)(7)(C) Health Services Administrator (Florence Facility), 25 IHSC employees, three ICE employees and five Core Civic employees.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.
The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive to maintain their high level of professionalism in the correctional field.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Performance Based Standards Health Care for Adult Local Detention Facilities, 4th Edition	
Supplement	2016 Standards Supplement	
Facility/Program	Eloy Detention Center (IHSC)	
Audit Dates	March 12-13, 2018	
Auditor(s)	(b)(6); (b)(7)(C) Chairperson (b)(6); (b)(7)(C) Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	20	31
Number Not Applicable	0	2
Number Applicable	20	29
Number Non-Compliance	0	0
Number in Compliance	20	29
Percentage (%) of Compliance	100%	100%

- Number of Standards minus Number of Not Applicable equals Number Applicable
- Number Applicable minus Number Non-Compliance equals Number Compliance
- Number Compliance divided by Number Applicable equals Percentage of Compliance

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps (IHSC)
Eloy Detention Center (IHSC)
Eloy, Arizona

March 12-13, 2018

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-4D-04

A HEALTH- TRAINED STAFF MEMBER COORDINATES THE HEALTH DELIVERY SERVICES UNDER THE JOINT SUPERVISION OF THE RESPONSIBLE HEALTH AUTHORITY AND FACILITY ADMINISTRATOR, WHEN QUALIFIED HEALTH CARE PERSONNEL ARE NOT ON DUTY.

FINDINGS:

EDC-IHSC has a qualified health care staff on duty to coordinate the health delivery services.

Standard #4-ALDF-4D-11

UNLESS PROHIBITED BY STATE LAW, INMATES (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE:

- PEER SUPPORT AND EDUCATION
- HOSPICE ACITIVITIES
- ASSISTING IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH ACTVITIES OF DAILY LIVING
- SUICIDE COMPANION OR BUDDY IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF A SUICIDE PREVENTION PLAN
- HANDLING OF DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITATION AND CLEANING WHEN WORKING AS A DENTAL ASSISTANT WHILE IN A TRAINING PROGRAM THAT IS CERTIFIED BY A STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY (INMATES MUST BE UNDER DIRECT

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SUPERVISION AND IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES)

INMATES ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMINING ACCESS OF OTHER INMATES TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALTY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

EDC-IHSC does not use detainees to perform familial duties.

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Significant Incident Summary
This report is required for all residential accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Eloy Detention Center (IHSC)
Reporting Period: Jan 2017-Dec 2017

Incident Type	Months ⇨	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUNE 2017	JULY 2017	AUG 2017	SPT 2017	OCT 2017	NOV 2017	DEC 2017	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	1	2	2	3	1	3	4	2	4	3	6	1	32
	Offender/ Staff	2	2	1	2	1	1	1	2	1	0	3	2	18
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Name of Facility: Eloy Detention Center Date: 2017
Number of Months Data Collected: 12

		ALDF Outcome Measure Worksheet		
1A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from injury and illness caused by the physical environment.**	**Value**	**Calculated O.M**
	(1)	Number of worker compensation claims filed for injuries that resulted from the physical environment in the past 12 months.	0	
	divided by	Average number of Full-Time Equivalent (FTE) staff positions in the past 12 months.	77	0
	(2)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1375	0
	(3)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	7104	0
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(5)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	7104	0
	(6)	Number of sanitation or health code violations identified by external agencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(7)	Number of health code violations corrected in the past 12 months.	0	
	divided by	The number of health code violations identified in the past 12 months.	0	0
	(8)	Number of inmate grievances related to safety or sanitation found in favor of inmates in the past 12 months.	5	
	divided by	The number of inmate's grievances related to safety or sanitation in the past 12 months.	18	0.278

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	(9)	Number of fire code violations corrected in the past 12 months.	0	
	divided by	The number of fire code violations cited by jurisdictional authority in the past 12 months.	0	0
	(10)	Number of inmate injuries resulting from fires requiring medical treatment in a 12-month period.	0	
	divided by	The average daily population in the past 12 months.	1375	
	(11)	Number of inmate injuries (other than by fire) requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1375	0
	(12)	Number of staff injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of staff in the past 12 months.	85	0
	(13)	Number of staff injuries (other than fire) requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of staff in the past 12 months.	85	0
	(14)	Number of inmate lawsuits related to safety or sanitation found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate lawsuits related to safety or sanitation in the past 12 months.	0	0
1C		**The number and severity of emergencies are minimized. When emergencies occur, the response minimizes the severity.**		
	(1)	Number of emergencies, caused by forces external to the facility, that result in property damage in the past 12 months.	0	
	divided by	The number emergencies.	0	0
	(2)	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(3)	Number of times that normal facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(4)	Number of hours that facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies caused by forces external to the facility.	0	0

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	(5)	Number of emergencies that were not caused by forces external to the facility that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(6)	Number of injuries requiring medical attention that resulted from emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(7)	Number of times that normal facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(8)	Number of hours that facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies.		
	(9)	Number of injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(10)	Number of fires that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(11)	Amount dollar of property damage from fire in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(12)	Number of code violations cited in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(13)	Number of incidents involving toxic or caustic materials in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(14)	Number of incidents of inventory discrepancies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
2A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from harm. Events that pose risk of harm are prevented. The number and severity of events are minimized.**	**Value**	**Calculated O.M**
	(1)	Number of incidents involving harm in the past 12 months	0	

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	divided by	The average daily population in the past 12 months.	1375	0
	(2)	Number of incidents in the past 12 months involving harm.	0	
	divided by	The number of admissions in the past 12 months.	7104	0
	(3)	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the incidents in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	7104	0
	(5)	Number of unauthorized inmate absences from the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(6)	Number of instances of unauthorized access to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
4B		**Inmates maintain acceptable personal hygiene practices.**		
	(1)	Inmate grievances regarding inmate access to personal hygiene decided in favor of the inmate in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	
	(2)	Number of inmate illnesses attributed to poor hygiene practices in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	13754	
	(3)	Number of inmates diagnosed with hygiene-related conditions (scabies, lice, or fungal infections) in the past 12 months.	7	
	divided by	The average daily population in the past 12 months.	1375	0.005
	(4)	Number of inmate grievances related to hygiene found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate grievances related to hygiene in the past 12 months.	1	0
	(5)	Number of inmate lawsuits related to hygiene found in favor of the inmate in the past 12 months.	0	0
	divided by	The number of inmate lawsuits related to hygiene in the past 12 months.	0	0
4C		**Inmates maintain good health. Inmates have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner.**		
	(1)	Number of inmates with a positive tuberculin skin	46	

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		test in the past 12 months.		
	divided by	The number of admissions in the past 12 months.	7104	0.006
	(2)	Number of inmates diagnosed with active tuberculosis in the past 12 months.	18	
	divided by	The average daily population in the past 12 months.	1375	0.013
	(3)	Number of conversions to a positive tuberculin skin test in the past 12 months.	0	
	divided by	The number of tuberculin skin tests given in the past 12 months.	369	0
	(4)	Number of inmates with a positive tuberculin skin test who completed prophylaxis treatment for tuberculosis in the past 12 months.	1	
	divided by	The number of inmates with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months.	1	1
	(5)	Number of Hepatitis C positive inmates in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	1375	0.0014
	(6)	Number of HIV positive inmates in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	1375	0.0014
	(7)	Number of HIV positive inmates who are being treated with highly active antiretroviral treatment in the past 12 months.	18	

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	divided by	The number of known HIV positive inmates in the past 12 months.	20	0.9
	(8)	Number of offenders with an individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time.	116	
	divided by	The average daily population in the past 12 months.	1375	0.084
	(9)	Number of inmate suicide attempts in the past 12 months.	4	
	divided by	The average daily population in the past 12 months.	1375	0.002
	(10)	Number of inmate suicides in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(11)	Number of inmate deaths due to homicide in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(12)	Number of inmate deaths due to injuries in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	13	0
	(13)	Number of medically expected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(14)	Number of medically unexpected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(15)	Number of inmate admissions to the infirmary (where available) in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(16)	Number of inmate admissions to off-site hospitals in the past 12 months.	36	
	divided by	The average daily population in the past 12 months.	1375	0.26
	(17)	Number of inmates transported off-site (via an ambulance or correctional vehicle) for treatment of emergency health conditions in the past 12 months.	198	
	divided by	The average daily population in the past 12 months.	1375	0.144
	(18)	Number of inmate specialty consults completed in the past 12 months.	1200	
	divided by	The number of specialty consults (on-site or off-site) ordered by primary health care provider (MD, NP, PA) in the past 12 months.	1317	0.911
	(19)	Number of inmate grievances about access to health care services found in favor of the inmate in the past 12 months.	1	
	divided by	The number of inmate grievances about access to	64	0.016

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		healthcare services in the past 12 months.		
	(20)	Number of inmate grievances related to the quality of health care found in favor of inmates in the past 12 months.	1	
	divided by	The number of inmate grievances related to the quality of health care in the past 12 months.	53	0.019
	(21)	Number of inmates' lawsuits about access to healthcare services found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate's lawsuits about access to healthcare services in the past 12 months.	0	0
	(22)	Number of individual sick call encounters in the past 12 months.	12006	
	divided by	The average daily population in the past 12 months.	1375	8.731
	(23)	Number of physician visits contacts in the past 12 months.	720	
	divided by	The average daily population in the past 12 months.	1375	0.524
	(24)	Number of individualized dental treatment plans in the past 12 months.	255	
	divided by	The average daily population in the past 12 months.	1375	0.185
	(25)	Number of hypertensive inmates enrolled in a chronic care clinic in the past 12 months.	383	
	divided by	The average daily population in the past 12 months.	1375	0.279
	(26)	Number of diabetic inmates enrolled in a chronic care clinic in the past 12 months.	248	
	divided by	The average daily population in the past 12 months.	1375	0.180
	(27)	Number of incidents involving pharmaceuticals as contraband in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1375	0
	(28)	Number of cardiac diets received by inmates with cardiac disease in the past 12 months.	156	
	divided by	The number of cardiac diets prescribed in the past 12 months.	275	0.567
	(29)	Number of hypertensive diets received by inmates with hypertension in the past 12 months.	202	
	divided by	The number of hypertensive diets prescribed in the past 12 months.	325	0.621
	(30)	Number of diabetic diets received by inmates with diabetes in the past 12 months.	248	
	divided by	The number of diabetic diets prescribed in the past 12 months.	248	1
	(31)	Number of renal diets received by inmates with renal disease in the past 12 months.	2	
	divided by	The number of renal diets prescribed in the past 12 months.	2	1

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	(32)	Number of needle-stick injuries in the past 12 months.	0	
	divided by	The number of employees on average in the past 12 months.	85	0
	(33)	Number of pharmacy dispensing errors in the past 12 months.	2	
	divided by	The number of prescriptions dispensed by the pharmacy in the past 12 months.	23876	0.000083
	(34)	Number of nursing medication administration errors in the past 12 months.	34	
	divided by	The number of medications administered in the past 12 months.	3996	0.010
4D		**Health services are provided in a professionally acceptable manner. Staff are qualified, adequately trained, and demonstrate competency in their assigned duties.**		
	(1)	Number of staff with lapsed licensure and/or certification in the past 12 months.	0	
	divided by	The number of licensed or certified staff in the past 12 months.	54	0
	(2)	Number of new employees in the past 12 months who completed orientation training prior to undertaking job assignments.	12	
	divided by	The number of new employees in the past 12 months.	12	0
	(3)	Number of employees completing in-service training requirements in the past 12 months.	12	
	divided by	The number of employees eligible in the past 12 months.	12	1
	(4)	Number of MD staff who left employment in the past 12 months.	1	
	divided by	The number of authorized MD staff positions in the past 12 months.	1	1
	(5)	Number of RN staff who left employment in the past 12 months.	2	
	divided by	The number of authorized RN staff positions in the past 12 months.	27	0.074
	(6)	Number of LPN staff who left employment in the past 12 months.	0	
	divided by	The number of authorized LPN staff positions in the past 12 months.	14	0
	(7)	Number of medical records staff who left employment in the past 12 months.	1	
	divided by	The number of medical records staff positions in the past 12 months.	6	0
	(8)	Number of alleged sexual misconduct incidents	0	

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		between staff and detainees in the past 12 months.		
	divided by	Average daily population in the past 12 months.	1375	0
	(9)	Number of alleged sexual misconduct incidents between volunteers and/or contract personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1375	0
	(10)	Number of confirmed sexual misconduct incidents between staff and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1375	0
	(11)	Number of confirmed sexual misconduct incidents between volunteers and/or contact personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1375	0
	(12)	Number of detainees identified as high risk with a history of sexually assaultive behavior in the past 12 months.	Core Civic	
	divided by	Average daily population in the past 12 months.	1375	
	(13)	Number of detainees identified as at risk for sexual victimization in the past 12 months.	Core Civic	
	divided by	Average daily population in the past 12 months.	1375	

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COMMISSION ON ACCREDITATION FOR CORRECTIONS
PANEL ACTION REPORT

Minneapolis Convention Center
Minneapolis, Minnesota

Saturday, August 4, 2018

Agency Name: ICE Health Service Corps (IHSC)
Facility Name: Eloy Detention Center (IHSC)
Facility Location: Eloy, Arizona

Agency Representatives: (b)(6); (b)(7)(C)

Panel Members: (b)(6); (b)(7)(C)

Staff:

No panel actions are required.

Accreditation Panel Decision

Moved: Commissione (b)(6); (b)(7)(C)
Seconded: Commissione

Three-Year Accreditation: Yes

Accreditation Vote	**Yes**	**No**
Commissioner (b)(6); (b)(7)(C)	✓	
Commissioner	✓	
Commissioner	✓	
Commissioner	✓	

Final Tally

Mandatory	100%
Non-Mandatory	100%

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American Correctional Association

ACCREDITATION REPORT

Commission on Accreditation for Corrections

ICE Health Service Corps
Northwest Detention Center
Tacoma, Washington

The mission of the Commission on Accreditation for Corrections is to upgrade and improve practices and conditions in adult and juvenile correctional facilities and programs through an accreditation process which is founded on a commitment to accountability, professionalism and respect for basic human rights and which recognizes sound and effective correctional practices, while striving towards excellence in the field of corrections.

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American Correctional Association

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March 12, 2018

ICE Health Service Corps (IHSC)
Northwest Detention Center (IHSC)
Tacoma, Washington

Congratulations!

It is a pleasure to officially inform you that the Northwest Detention Center (IHSC) was accredited by the Commission on Accreditation for Corrections at the American Correctional Association 2018 January Conference on January 8, 2018 in Orlando, Florida.

Your accreditation represents the satisfactory completion of a rigorous self-evaluation, followed by an outside review by a team of experienced, independent auditors.

Every profession strives to provide a high quality of service to society. To know that you, your staff, and other officials are complying with the requirements of the accreditation process is indeed a statement of a high level of commitment to the staff and persons under your care.

On behalf of the American Correctional Association and the Commission on Accreditation for Corrections, thank you for your commitment to the corrections profession and to the accreditation process.

Sincerely,

Denise M. Robinson

Denise Robinson, Chairperson
Commission on Accreditation for Corrections

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For Immediate Release

Northwest Detention Center (IHSC) Awarded National Accreditation

Denise Robinson, Chairperson of the Commission on Accreditation for Corrections (CAC), and Bridget Bayliss-Curren, Director of Standards and Accreditation, American Correctional Association recently announced the accreditation of the Northwest Detention Center (IHSC). The award was presented in conjunction with the American Correctional Association 2018 Winter Conference on January 8, 2018 in Orlando, Florida.

In presenting the award, Denise Robinson, Chairperson of the CAC, and Lannette Linthicum, President of the American Correctional Association (ACA), complimented the facility on their professional level of operation and their success in completing the accreditation process. The agency is one of over 1,500 correctional organizations currently involved in accreditation across the nation.

The accreditation program is a professional peer review process based on national standards that have evolved since the founding of the Association in 1870. The standards were developed by national leaders from the field of corrections, law, architecture, health care, and other groups who are interested in sound correctional management.

ACA standards address services, programs, health care and security operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for agencies and facilities throughout the world.

The three-year accreditation award granted to the Northwest Detention Center (IHSC) does not signal the end of their involvement in the accreditation process. During the award period, staff will work to improve any deficiencies identified during the audit and maintain continuous compliance with the standards.

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Congratulations on your accreditation award! You are now a member of the elite in achieving correctional excellence. The certificate you have received is but a small symbol of the enormous dedication and commitment demonstrated by each and every member of your staff to the accreditation process, and I urge you to display it prominently as a continual reminder of the level of professionalism achieved. This is just the beginning of your journey, however, for the true test of excellence is the test of time. It is critical that your operation be able to sustain this achievement over time and be constant through both prosperity and adversity.

Achieving American Correctional Association Accreditation means you have demonstrated your dedication to getting the job done right, and that you are holding your agency to a higher standard.

Thank you for your commitment to the American Correctional Association and the accreditation process.

Bridget Bayliss Curren

Bridget Bayliss-Curren,
Director Standards and Accreditation
American Correctional Association

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Overview of the American Correctional Association

The American Correctional Association (ACA) is a professional membership organization composed of individuals, agencies and organizations involved in all facets of the corrections field, including adult and juvenile services, community corrections, probation and parole and jails. It has thousands of members in the United States, Canada and other nations, as well as over 100 chapters and affiliates representing states, professional specialties, or university criminal justice programs. For more than 145 years, ACA has been the driving force in establishing national correctional policies and advocating safe, humane and effective correctional operations. Today, ACA is the world-wide authority on correctional policy and standards, disseminating the latest information and advances to members, policymakers, individual correctional workers and departments of correction. ACA was founded in 1870 as the National Prison Association and became the American Prison Association in 1907.

At its first meeting in Cincinnati, the assembly elected Rutherford B. Hayes, then governor of Ohio and later U.S. president, as the first president of the association. At that same meeting, a *Declaration of Principles* was developed, which became the accepted guidelines for corrections in the United States and Europe. At the 1954 annual Congress of Correction in Philadelphia, the name of the American Prison Association was changed to the American Correctional Association, reflecting the changing philosophy of corrections and its increasingly important role in society.

Since that time, ACA has continued to take a leadership role in corrections and work toward a professional unified voice in correctional policy. In recent years, one of the Association's major goals has been the development of national and international policies and resolutions of significant issues in corrections. Policies are considered for ratification at the Association's two annual conferences and ratified policies are then widely disseminated. Since its formation, ACA has also had a major role in designing professional standards, and more recently performance based standards and expected practices, for correctional organizations. Since the early 1980s ACA has been involved in a program of accreditation to recognize programs representing excellence in more than 20 different disciplines within the field, with emphasis on evidenced based practices.

Membership in ACA is open to any individual, agency, or organization interested in corrections and the purposes and objectives of the Association. Members include the majority of state, local, provincial, and territorial correctional agencies, individual correctional institutions, local jails, pretrial programs and agencies, juvenile justice programs, schools of criminal justice in colleges and universities, libraries, and various probation, parole, and correctional agencies. Many of ACA's members are employed at federal, military, private, state, and local agencies. Members also include volunteers affiliated with these agencies as service providers or as members of advisory boards and committees.

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Organizational Purposes of the American Correctional Association

Among the most significant purposes of the Association as outlined in its Constitution, are:

- *To provide a professional association of persons, agencies, and organizations, both public and private, who hold in common the goal of improving the profession of corrections and enhancing their contribution to that profession.*

- *To broaden and strengthen support for the Association's goals by advocating Association policies, resolutions, positions, and standards to policymakers and the public and by forming coalitions with other professional organizations sharing these goals.*

- *To develop standards for all areas of corrections and implement a system for accreditation for correctional programs, facilities and agencies based on these standards. Where feasible, standards shall be based on performance outcome.*

- *To conduct or sponsor corrections conferences, congresses, institutes, forums, seminars and meetings.*

- *To publish and distribute journals and other informative materials relating to criminology, crime prevention, and corrections and to encourage and stimulate research of these matters.*

- *To promote recognition of corrections as a profession, and those who work in corrections as professionals, and to ensure validity of that recognition by encouraging the recruitment and development of highly qualified corrections professionals, and by developing and implementing a certification program for corrections professionals*

In carrying out these purposes, ACA supports programs for policy analysis, demonstration, effective delivery of health services to offender populations and research. ACA also provides testimony, consultation, publications, conferences, workshops, and other activities designed to stimulate constructive action regarding correctional issues.

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Organizational Structure of the American Correctional Association

Executive Committee

The Executive Committee is composed of the elected officers of the Association - president, vice president, treasurer, two Board of Governors members, the immediate past president, the president-elect, and the ACA executive director. The Executive Committee meets at least quarterly and exercises most of the powers of the Board of Governors during the intervals between meetings of the board.

Board of Governors

ACA's bylaws vest control of the Association with a 19-member elected Board of Governors composed of the officers of the Association and five at-large members. The 19 elected governors shall general reflect the Association's composition. The following areas of practice shall be represented by at least one board member:

Correctional Administration
Institutions
Juvenile
Probation
Community Programs
Detention
Education
Health Care
Parole, Aftercare or Post-Release Supervision

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Delegate Assembly

The Delegate Assembly is composed of delegates from the professional affiliates, geographical chapters, membership at-large, Board of Governors, past presidents of ACA, and representatives of each military service. The Delegate Assembly can establish policy, define Association positions on broad social and professional issues, and determine major programs and legislative priorities. They meet at least twice annually, at the Winter Conference and Congress of Correction.

Committees

The majority of the Association's activities take place through committees. Each committee chair reports to the Association's Board of Governors at least twice a year. In this way, the Association collectively benefits from the involvement and contribution of the hundreds of individuals who function on the various committees. Ad-hoc committees are appointed by the president of the Association.

Affiliates and Chapters

Affiliates and state chapters are major features of the Association's structure. They represent professional, regional, and state groups across the United States and Canada. Affiliates and chapters contribute to the professional development of all members by providing consultation in their respective areas of interest and by participating in seminars and workshops at ACA's annual conferences.

Major Activities of the American Correctional Association

Legislation

The American Correctional Association is involved with all major issues affecting corrections today. Members and ACA staff maintain close working relationships with committees of the U.S. Congress and all federal agencies and groups whose decisions affect correctional policy. Expert testimony on a wide range of correctional issues is prepared for congressional committee and subcommittee hearings, and recommendations are provided to federal administrative agencies.

To ensure that the concerns and issues of the corrections profession are represented in proposed legislation and public policy, ACA's legislative liaison is addressing legislative and government concerns that will impact the corrections profession. ACA has established partnerships between chapters and affiliates and other national policy making organizations to present a strong collective voice for correctional reform throughout the world.

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ACA's Office of Correctional Health serves ACA members, jurisdictions and its affiliates by supporting health services programs for the effective delivery of health to offender populations. We offer comprehensive services, support, and resources to help correctional facilities provide security and quality care for the offender population. The office is responsible for improving ACA's performance-based health care standards, trainings and the health certification program. The health certification program includes Nurse, Nurse Manager, Health Services Administrator and Correctional Behavioral Health.

Professional Development

The purpose of the Association's Professional Development Department is to plan, promote, and coordinate professional development through training seminars, workshops, and published materials including curriculums, resource guides, and monographs.

ACA's training plan calls for a variety of professional development activities. Nationally advertised workshops cover topics such as training for trainers, management training, community-based employment programs, and stress management. On-site workshops for state and local departments of corrections are offered in curriculum development, supervision, communications, and report-writing skills.

The *Training for Correctional Staff Trainers* workshops further the skills of correctional professionals qualified to initiate and deliver training. These workshops also enable agencies to comply with national standards for accreditation and ensure that training is job- related and professionally developed and presented.

The department also offers correspondence courses to further professional development. More than 6,000 correctional personnel have completed or are in the process of completing ACA's self-instruction training program for correctional officers. This program, developed under the auspices of the National Institute of Corrections, provides 40 hours of basic training in accordance with ACA standards. A score of at least 80 percent on the comprehensive examination must be attained to achieve certification.

The Association has similar courses available for correctional supervisors, juvenile caseworkers, and food service employees. Additional courses which cover report writing skills, correctional management skills, legal issues for probation and parole officers, and legal issues for correctional officers are also available.

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Publications

As one of the leading publishers of practical correctional publications, ACA produces books, videos, and lesson plans. Among the wide ranging subjects available are management, community, security, counseling, law, history, and health. These excellent resources for career advancement appeal to practitioners and scholars alike. Directories for every major sector of corrections are also published by ACA.

The following is just a few of the many publications that ACA offers:

Corrections Today is the major corrections magazine in the United States. Published seven times a year, it focuses on the interests of the professional correctional employee and administrator. Articles include reports of original research, experiences from the field, discussion of public policy, and the perspectives of prominent practitioners and academicians.

Correctional standards are the most significant improvement in correctional programming. As the basis for accreditation, they give administrators a nationally recognized system for upgrading and improving their correctional services. The Association currently publishes over 20 manuals for every correctional discipline.

To aid in the development of policy with relation to accreditation, *Guidelines for the Development of Policies and Procedures* are available for adult correctional institutions, adult parole authorities/adult probation and parole field services, adult local detention facilities, adult community residential services, juvenile detention facilities, and juvenile training schools.

Conventions

ACA hosts two national conventions each year that attract more than 5,000 professionals from all aspects of corrections; the Winter Conference held in January, and the Congress of Correction, held in August. These events include a variety of workshops, exhibits, and seminars devoted to addressing topics specific to the corrections profession.

Performance Standards and Accreditation

Perhaps ACA'S greatest influence has been the development of national standards and the accreditation process. ACA performance standards address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Performance standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for over 1,500 correctional agencies in the United States. ACA has continued this progress with the promulgation of the performance based standard and expected practice format.

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Overview of the Commission on Accreditation for Corrections

The Commission on Accreditation for Corrections (CAC) is a private, nonprofit organization established in 1974 with the dual purpose of developing comprehensive, national standards for corrections and implementing a voluntary program of accreditation to measure compliance with those standards.

The Commission was originally developed as part of the American Correctional Association. In 1979, by joint agreement, the Commission separated from the Association in order to independently administer the accreditation program. Between 1978 and 1986, the organizations shared the responsibility for developing and approving standards and electing members of the Commission. On November 7, 1986, the Commission on Accreditation for Corrections officially realigned itself with the American Correctional Association.

The Commission is governed by a Board of Commissioners who reflect the Association's composition, including adult and juvenile components; the geographical distribution of its membership; and representation of ethnic and racial minorities, women, and management and non-management staff. The responsibility of rendering accreditation decisions rests solely with the Commission.

They represent the following specific categories:

Correctional Administration
Juvenile
Institutions
Probation
Parole, Aftercare or Post-Release Supervision
Community Programs
Detention
Education
Health Care
Legal
Architecture
Non-correctional administration

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Association Staff

Accreditation activities are supported by the staff of the American Correctional Association, Standards and Accreditation Department, under the leadership of the director of the department. Standards and Accreditation Department staff is responsible for the daily operation of the accreditation program. Agencies in the process have contact primarily with the accreditation specialist responsible for their state or agency.

Auditors

Auditors are corrections professionals who have been selected, trained, and certified by the Association. These individuals perform the field work for the Association which includes providing assistance to agencies working toward accreditation and conducting on-site audits of agencies to assess compliance with program requirements. In certain cases, when the Commission believes it necessary, they monitor agencies to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to as Visiting Committees, are formed to conduct compliance audits of agencies seeking accreditation and reaccreditation.

Auditors are recruited through announcements in prominent criminal justice publications, online and at major correctional meetings. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All auditors have a minimum of five years of corrections experience, have received a recommendation from an agency administrator, and have demonstrated knowledge in the substantive area(s) in which they are engaged to assist the Association. In addition, all auditors must successfully complete the auditor orientation course (found at www.aca.org), participate in an ACA sanctioned training every three years (check out www.aca.org for details on training dates and times) and be members of the ACA in good standing. All auditors are approved by ACA.

Performance Based Standards and Expected Practices Development

Development of the traditional ACA standards began in 1974 with an extensive program of drafting, field testing, revising, and approving them for application to all areas of corrections. Since then; local, state, national and international correctional facilities and programs have adopted the traditional standards, performance standards, and expected practices as outlined in ACA's accreditation manuals, for implementation through accreditation.

Steps are taken to ensure that accreditation manuals' development efforts reflect the best judgment of corrections professionals regarding good corrections practice. Traditional standards, performance standards, and expected practices endeavor to be clear, relevant, and comprehensive. The development and approval process for traditional standards, performance standards, and expected practices has involved participation by a wide range of concerned individuals and organizations and over twenty accreditation manuals are now used in the accreditation process:

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Performance-Based Core Jail Standards-First Edition
Performance-Based International Correctional Core Standards- Adult
Performance-Based International Correctional Core Standards- Juvenile
Performance-Based Standards for Adult Community Residential Services -–Fourth Edition
Performance-Based Standards for Adult Local Detention Facilities-–Fourth Edition
Performance-Based Standards for Adult Probation and Parole Field Services
Performance-Based Standards for Correctional Industries
Performance-Based Standards for Juvenile Correctional Facilities -- Second Edition
Performance-Based Standards for Therapeutic Communities
Performance-Based Health Care Standards for Adult Correctional Institutions
Performance-Based Health Care Standards for Adult Local Detention Facilities
Performance-Based Health Care Standards for Juvenile Correctional Facilities, 4th Edition
Standards for Administration of Correctional Agencies - Second Edition
Standards for Adult Correctional Boot Camps Programs
Standards for Adult Correctional Institutions –Fourth Edition
Standards for Adult Parole Authorities - Second Edition
Standards for Correctional Training Academies
Standards for Electronic Monitoring Programs
Standards for Food Service Programs
Standards for Juvenile Community Residential Facilities –3rd Edition
Standards for Juvenile Correctional Boot Camps
Standards for Juvenile Day Treatment Programs
Standards for Juvenile Detention Facilities -–3rd Edition
Standards for Juvenile Probation and Aftercare Services –Second Edition
Standards for Small Juvenile Detention Facilities

Performance based standards and expected practices establish clear goals and objectives critical to the provision of constitutional and humane correctional programs and services. The performance based standards include the requirement for practices to promote sound administration and fiscal controls, an adequate physical plant, adherence to legal criteria and provision of basic services. Basic services called for by the standards include the establishment of a functional physical plant, training of staff, adoption of sanitation and safety minimums, and provision of a safe and secure living environment. In offering specific guidelines for facility and program operations, the manuals of standards address due process and discipline, including access to the courts, mail and visitation, searches, and conditions of confinement of special management offenders.

In January 1996, ACA's Standards Committee (known today as the Performance Standards Committee) adopted innovative new guidelines for the development of *performance-based* professional standards. In August 1996, ACA President Bobbie Huskey published an article "Measuring Performance: ACA's New Paradigm in the Making," in *Corrections Today* which suggested that moving toward performance measurement required "a fundamental shift in thinking" for the field.

Without exception, the drafters of the new performance-based model found that all prior traditional standards described *activities* or *expected practices* that were prescribed for practitioners. The performance-based model, they believed, should emphasize *conditions* to be achieved and maintained.

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In August 2000, in San Antonio, Texas, the Performance Standards Committee adopted the Adult Community Residential Services Performance Based Accreditation manual. For two decades, the ACA has been engaged in the transition of the traditional standards and accreditation system from one that has been focused on the evaluation of acceptable practices from the perspective of process evaluation to one that is fundamentally linked to the measurement of outcomes resulting from the adoption of professional practices. This evolution evolves from the recognition that the measurement of the successful completion of a process or activity is not sufficient for accreditation purposes. The process must also evaluate and measure the results, the outcomes, of such practices.

To that end, involvement in accreditation now requires an understanding of general "performance standards" and the definition of expected practices and specific measurable outcomes associated with them. This is the foundation of the transition to the performance based model.

The term "performance-based standard" or "performance standard" is not the equivalent of the traditional term "standard". The traditional "standard" is replaced by "expected practice" in the performance-based system and has no further utilization in the new performance-based system.

In the traditional accreditation process, validation of compliance with the standards was accomplished through the generation and organization of primary and secondary documentation. The equivalent system exists in the performance based system except that primary documentation has been renamed "protocols" and secondary documentation has been renamed "process indicators". Primary and secondary documentation, now termed protocols and process indicators comprise the essential elements of the performance based compliance file from the agency/program perspective. The concept and documentation of protocols is identical to that of the traditional manual's primary documentation. The concept and documentation of process indicators is identical to that of the traditional manual's secondary documentation.

Through this transition, the accreditation process establishes clear goals and objectives critical to the provision of safe, constitutional, effective and humane correctional programs and services. Accreditation addresses services, programs, and operations essential to good correctional practice, including safety, security, order, care, programming, justice and administration and management.

Revision Process

The performance standards and expected practices are systematically revised, and new performance standards and expected practices considered, to keep pace with the evolution of correctional practices and law and performance benchmarks. After careful examination, the ACA Performance Standards Committee determines revisions and updates as necessary.

Suggestions and proposals for revisions to the performance standards or expected practices from the field and others interested are encouraged.

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The Performance Standards Committee meets before each ACA Conference to review proposed performance standards and expected practices, (as well as traditional standards not yet converted to the performance based model). Proposals from the field should be submitted via the ACA website at www.aca.org. The portal is opened for submissions approximately 5 months prior to the next scheduled ACA Conference and remains open for at least 8 weeks. The portal is then closed and the submitted revisions are formatted appropriately. They are then posted on the ACA website, at www.aca.org, for the field to comment on for a period of 4 weeks after which the submissions and comments are taken down and compiled for the Performance Standards Committee's consideration at the upcoming conference. The minutes from the Committee are posted on the ACA website within 4 weeks of the end of the conference.

These changes are published by ACA through revision to appropriate agency accreditation manuals as necessary upon the conclusion of semi-annual meetings of the Performance Standards Committee. Agencies are responsible for compliance with the expected practices in effect at the beginning of the 3 year accreditation cycle. However, agencies may choose to apply new changes to the expected practices that have been issued following the program's entry into accreditation but prior to their next contract inception. In selecting to meet the revised expected practices, agencies are required to notify their Accreditation Specialist of their decisions to do so as soon as possible before the next compliance audit. The Accreditation Specialist will ensure the information is provided to the Visiting Committee.

Accreditation Process Descriptions

For over 120 years, the American Correctional Association has been the only national body involved in the development of standards for the correctional field. ACA standards are supported by ACA's Standards and Accreditation Department and the Commission on Accreditation for Corrections, which is the evaluating and certifying body for accreditation. The department is responsible for the administration of accreditation and ongoing development of correctional standards.

The accreditation process is a voluntary program for all types of correctional agencies. For these agencies, accreditation offers the opportunity to evaluate their operations against national standards, to remedy deficiencies, and to upgrade the quality of programs and services. The recognized benefits of such a process include: improved management; a defense against lawsuits through documentation; demonstration of a "good faith" effort to improve conditions of confinement; increased accountability and enhanced public credibility for administrative and line staff; a safer and more humane environment for personnel and offenders; and the establishment of measurable criteria for upgrading programs, staffing, and physical plant on a continuous basis.

A major component of the accreditation process is the standards compliance audit conducted by a visiting committee. The purpose of the audit is to measure operations against the standards, based on documentation provided by the agency.

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The Visiting Committee Report

The results of the compliance audit are contained in the Visiting Committee report. The finished report consists of a number of sections, which are compiled through an exchange of information between the Visiting Committee, the agency, and Performance Based Standards & Expected Practices Accreditation Department staff. The report is sent to agency staff for review and distribution to the agency administrator. The completed Visiting Committee report is submitted to the Commission for consideration at the next regularly scheduled panel hearing.

The following information is usually contained in the visiting committee report:

Audit Narrative - This section is prepared by the Visiting Committee chairperson and includes a description of program services, physical plant and number of offenders served on the date of the audit. It also details audit activities and findings, including issues or concerns that may affect the quality of life and services in an agency or facility, as well as information and impressions obtained during interviews with staff and offenders. The quality of life issues include the level of staff training, adequacy of medical services, sanitation, restricted housing, patterns of violence, and crowding in institutions, (including effects on housing (double-celling), offender activity levels, programs, and provision of basic services).

Compliance Tally - The tally is completed by the audit chairperson using a form prepared by the Performance Based Standards & Expected Practices Accreditation Department. Compliance percentages are calculated based on audit findings.

Audit Findings - Each expected practice found non-compliant or non-applicable is outlined, as well as the reasons for the findings.

Significant Incident Summary – The agency provides an electronic copy of this document to the Visiting Committee.

Annual Report – The agency provides its annual report on accreditation status (required annually for accredited facilities and as applicable for initial accreditation).

Outcome Measures (as applicable) - The agency provides an electronic copy of these documents to the Visiting Committee

Agency Response- The agency has three options for standards found in noncompliance: a plan of action; an appeal; or a waiver for the requirement of a plan of action request.

> A **plan of action** is a detailed statement of tasks to be performed in order to achieve compliance with a standard found in noncompliance at the time of the audit. The plan of action designates staff responsibilities and timetables for completion.
>
> An **appeal** is the agency's attempt to change the visiting committee's decision on a standard. The result of a successful appeal is a change in the

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status of the standard and a recalculation of the compliance tally.

A **waiver for the requirement of a plan of action** may be requested when noncompliance with a standard does not adversely affect the life, health, or safety of staff and offenders and when quality of life conditions compensate for the lack of implementation of a plan of action. The granting of a waiver by the Commission waives the requirement for submitting a plan of action; however, it does not change the non-compliant finding.

Auditor's *Response* - This section contains the Visiting Committee's final response to all comments received from the agency and Performance Based Standards & Expected Practices Accreditation Department staff, including:

- ✓ comments on agency appeals of the Visiting Committee's findings stating whether or not the committee agrees with the Appeal
- ✓ comments regarding the acceptance or rejection of Waiver requests
- ✓ comments on the acceptability of Plans of Action

Accreditation Hearings

The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers an agency's application at its next regular meeting following completion of the Visiting Committee report. The Commission is divided into panels that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include a quorum of at least three Commissioners which includes the panel hearing chairperson. Agencies are notified in writing of the date, time, and location of the hearings by Performance Based Standards & Expected Practices Accreditation Department staff.

With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented during the hearing and in the Visiting Committee report is considered by the panel members in rendering accreditation decisions.

The agency is invited to have a representative at the hearing and, in most cases, one or more individuals attend. When special conditions warrant, the Visiting Committee chairperson or a member of the Visiting Committee also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

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Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) occurs only with the permission of the applicant agency. In these cases, the applicant agency representatives and panel members discuss procedures to be followed before commencement of the hearing.

Conduct of Hearings

The panel schedule provides ample time for review of each individual agency pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures. Panel proceedings require that a formal vote be taken on all final actions, i.e., agency appeals, Waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- applicant agency representatives are requested by Performance Based Standards & Expected Practices Accreditation Department staff to be on-call to allow for scheduling flexibility
- a designated waiting area is usually provided for this purpose
- when the panel is ready to review the agency, the Performance Based Standards & Expected Practices Accreditation Department staff representative notifies agency representative(s)
- the hearing opens with an introduction by the panel chairperson
- the agency representative is asked to give a brief description of the program
- if a Visiting Committee member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the Visiting Committee member only to request additional information at different points during the hearing.
- the panel chairperson leads review of each individual non-compliance finding. The agency representative presents information relative to their requests for Waivers, Plans of Action, and appeals. The agency may also present additional materials, including photographs or documentation, for review by the panel.
- following the agency presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of agency personnel or in executive session, varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

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In final deliberations, the Commission panel:

- ensures compliance with all mandatory expected practices and at least 90 percent of all other expected practices
- responds with a formal vote to all appeals submitted by the applicant agency
- responds with a formal vote to all requests for Waivers, and Plans of Action submitted by the applicant agency

At this time, the panel also:

- assures that an acceptable Plan of Action will be submitted for every non-compliance finding, including those for which appeals of non-compliance and Waiver requests have been denied by the panel. In judging the acceptability of Plans of Action, the panel ensures that all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.

- addresses to its satisfaction any concerns it has with Visiting Committee comments about the quality of life in the facility or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to the life, health, and safety of residents and staff

Following each applicant hearing, a roll call vote is conducted to consider the award of accreditation, extend an agency in the accreditation process or deny accreditation.

If the panel has deliberated in executive session, agency representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant.

If accreditation has not been granted, the chairperson discusses with agency personnel specific reasons for the decision and the conditions of extension as well as procedures for appeal.

Accreditation Decisions

The decisions available to the Commission panel relating to the accreditation of an agency are:

- *Three-year accreditation award* based on sufficient compliance with expected practices, acceptance of adequate Plans of Action for all applicable non-compliant findings, (or approval of the Waivers of the requirement that a Plan of Action be submitted) and satisfaction of any other life, health, and safety conditions established by the panel.

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- *Extension of the applicant agency in initial accreditation process* (initial accreditation only) for reasons of insufficient compliance, inadequate Plans of Action, or failure to meet other requirements as determined by the panel, the Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the facility or program that adversely affect the life, health, or safety of the offenders or staff. Extension of an agency is for a period of time specified by the panel and for identified deficiencies if in the panel's judgment, the agency is actively pursuing compliance.

- Continuation of accreditation in *Probationary Status* after reaccreditation hearings is considered when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are quality of life issues that would indicate continued monitoring. Probationary Status lasts for a specific period of time designated by the Commission to allow for correction of deficiencies. While an award of accreditation is granted, a monitoring visit *must* be completed and the report presented at the next meeting of the Commission. At the end of the probationary status, another monitoring visit MAY be conducted to ensure that the deficiencies have been corrected. Following the visit, a report is prepared for review by the Commission at its next regularly scheduled meeting. The Commission again reviews the program and considers removing the probationary status or the revocation of accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted by the Commission on Accreditation of Corrections by the Commission on Accreditation of Corrections, the agency resumes its status as an accredited agency.

- *Denial of accreditation* denies initial accreditation or removes the agency from Accredited Status (in the case of reaccreditation) and withdraws the agency from the accreditation program. Situations such as insufficient compliance, inadequate Plans of Action, failure to meet other requirements as determined by the panel or quality of life issues may lead to the denial of accreditation. If an agency is denied accreditation by the panel, it is immediately appealed to the full commission. If the agency is denied accreditation by the full commission, it is withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing.

The agency receives written notification of all decisions relative to accreditation after the hearing.

Appeal Process

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status, or placement into probationary status. Therefore, if an agency is denied accreditation, it is immediately appealed to the full commission.

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If an agency is put in probationary status by the panel, it may submit an appeal of the placement into probationary status.

The basis for reconsideration of probationary status is based on grounds that the decision(s) were:

- ✓ A misinterpretation of the criteria and/or procedures promulgated by the Commission
- ✓ based on incorrect facts or an incorrect interpretation of facts
- ✓ unsupported by substantial evidence
- ✓ based on information that is no longer accurate

The reasonableness of the expected practices, criteria, and/or procedures for the process may not serve as the basis for reconsideration. The procedures for reconsideration are as follows:

- ✓ The agency can submit a verbal appeal immediately to the Director of Performance Based Standards & Expected Practices Accreditation or a written request for reconsideration within 30 days of the adverse decision stating the basis for the request.
- ✓ The Executive Committee of the Commission, composed of the officers of the Commission, reviews the request and decides whether or not the agency's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The agency is notified in writing of the Executive Committee's decision.
- ✓ If the decision is made to conduct a hearing, the hearing is scheduled for as soon as possible if the appeal is made verbally or if in writing, for the next full Commission meeting and the agency is notified of the date.
- ✓ The agency, at its option and expense, has the right of representation, including counsel.
- ✓ Following the hearing held before the Commission, the decision, reflecting a majority opinion, is made known to the agency immediately.
- ✓ Pending completion of the reconsideration process, the agency maintains its prior status. Until a final decision has been reached, all public statements concerning the agency's accredited status are withheld.
- ✓ Following completion of the reconsideration process, any change in the status of an agency is reflected in the next regularly published list of accredited agencies.

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Accredited Status

The accreditation period is three years, during which time the agency must maintain the level of compliance achieved during the audit and work towards compliance of those expected practices found in non-compliance. Regular contact with Performance Based Standards & Expected Practices Accreditation Department staff should also be maintained. The Annual Report, Critical Incident Report and Significant Incident Summary forms discussed below are available on the ACA website at www.aca.org or through your Accreditation Specialist.

Annual Report

During the three year accreditation period, the agency submits an annual report to the Performance Based Standards & Expected Practices Accreditation Department. This report is due on the anniversary of the accreditation (panel hearing) date utilizing the template provided by ACA staff (also available at www.aca.org). It contains the following information:

Current Compliance Levels - This includes any changes in compliance since accreditation, listing on a case by case basis any expected practice with which the agency has fallen out of compliance or achieved compliance.

Update of Plans of Action - A progress report is included with respect to Plans of Action submitted to the hearing panel, indicating the status of the completion of the plans. potential revision to plans reflecting the need to request additional time, funds, and/or resources to achieve compliance should also be included.

Significant Incident Report Summary - A report is made of events and occurrences at the agency during the preceding year that impact on compliance, agency operation, or the quality of services provided by the agency. Performance Based Standards & Expected Practices Accreditation Department staff review the annual report received from the agency and respond to clarify issues or request additional information if necessary.

Critical Incident Report

In addition to submission of the annual report, the agency is responsible for notifying Performance Based Standards & Expected Practices Accreditation Department staff of any critical incident that has the potential to affect compliance or facility accreditation as soon as possible within the context of the event itself. This information is to be submitted to ACA as soon as possible within the context of the incident itself, using the Critical Incident Report template available at www.aca.org.

Monitoring Visits

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) in order to assess continuing compliance. A monitoring visit may be conducted at any time during the accreditation period with notice to the agency. The determination of need for a monitoring visit is based on:

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- ➢ compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing
- ➢ incidents or events reported by the agency in its annual report and any Critical Incident Reports
- ➢ other incidents or reports that may indicate the need for on-site review

The length of the visit varies depending on the number of expected practices or special issues that must be addressed during the visit. Monitoring visits may be charged to the agency.

Monitoring visits, as a general rule, involve a review of all mandatory expected practices, all non-compliance findings at the time of accreditation, and any other concerns identified. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit.

The report includes a list of expected practiced reviewed, explanation of non-compliance findings, results of the tour and interviews with agency staff and offenders, and discussion of any issues believed to be relevant to the agency's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the agency by Performance Based Standards & Expected Practices Accreditation Department staff.

When a monitoring visit to the agency reveals deficiencies in maintaining adequate compliance levels, including less than 100 percent compliance with mandatory expected practices, the agency prepares a response providing explanation of the problems indicated in the report. When the agency has failed to maintain compliance with all mandatory expected practices, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections Executive Committee for review and referral to a Commission on Accreditation panel if necessary.

The Performance Based Standards & Expected Practices Accreditation Department may also request that the agency respond to public criticism, notoriety, or patterns of complaint about agency activity. The Performance Based Standards & Expected Practices Accreditation Department may conduct an on-site monitoring visit to the agency to verify continued compliance.

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Revocation of Accreditation

If a Commission panel believes that an agency's failure to maintain continuous compliance is detrimental to life, health, and safety of residents and staff, the Commission may place an agency on probation or revoke accreditation.

In the event information in annual reports, significant incident reports, or critical incident reports, or monitoring visits describe circumstances that would merit consideration of revocation of accreditation and the Commission on Accreditation for Corrections is not scheduled to be in session in a reasonable amount of time, the Commission on Accreditation of Corrections' Executive Committee may function as a panel for the purpose of consideration of the revocation action.

Expiration of Accredited Status

Accreditation is granted for a three-year period. Unless the agency has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the agency from Accredited Status after this three-year period.

When unanticipated extenuating circumstances occur, (which may include natural disaster, disturbance, or other significant operational disruption outside of the control of the program), that limit an accredited program's ability to present themselves as scheduled for reaccreditation audit and subsequent Commission on Accreditation for Corrections panel action, then the Commission on Accreditation for Corrections Executive Committee or the Executive Director acting on their behalf may extend the accreditation of the program beyond the reaccreditation date by placing them in probationary status pending resolution of the relevant issue and subsequent audit and Commission on Accreditation for Corrections Panel action.

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Visiting Committee Report and Hearing Minutes

CONFIDENTIALITY

The American Correctional Association and the Commission on Accreditation for Corrections do not disclose to external parties specific information contained in this Accreditation Report or information discussed in the Accreditation Hearing. The Association encourages all participating agencies to provide information to the media about their accreditation activities, including disclosure of the Self-Evaluation and Accreditation Report.

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

ICE Health Service Corps
Northwest Detention Center (IHSC)
Tacoma, Washington

September 25-26, 2017

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C)
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The audit of the Northwest Detention Center (IHSC), Tacoma, Washington was conducted on September 25-26, 2017 utilizing the American Correctional Association (ACA) Standards for Performance Based, Health Care for Adult Correctional Institution, 1st Edition and the 2014 Standards Supplement. The following team conducted the audit: Ernest Umunna, Chairperson and Randy Cross, Team Member. Although, this was a dual audit, there was a joint entrance and a separate exit conferences for the audit.

B. Facility Demographics

Rated Capacity: 1575 (Males - 1399 and Females - 176)
Actual Population: 1432 (Males - 1318 and Females - 114)
Average Daily Population for the last 12 months: 1429
Average Length of Stay: 0 Months: 85 days

(b)(7)(E)

Age Range of Detainees: 18-75
Gender: Male/Female

(b)(7)(E)

C. Facility Description

The Northwest Detention Center (NWDC) contracts with the Department of Homeland Security, Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operation (ERO) to house individuals, including male and female adults, who are pending immigration review. NWDC opened on April 23, 2004, with 500 contractual beds. In November 2005, the GEO Group, Inc. (GEO) acquired the (NWDC). The facility is physically located at 1623 East J Street, Tacoma Washington, about 40 minutes south of Seattle and 1.2 miles from the Tacoma Dome Bus Station. The facility is located on 15.3 acres in an industrial area of the city. The contractual capacity was increased from 500 to 800 beds in July 2006, and again to 1000 beds in January 2008. In October 2009, the contractual capacity was increased to 1575 as it currently stands.

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The demand for increased bed space necessitated an expansion of the institution's infrastructure and resulting in a major expansion project in November 2008. The project was completed in May 2010. Space was added to accommodate additional housing units and the third courtroom, as well as an extended office space for the administration areas for the ICE and GEO, Additionally, two outdoor recreation yards were constructed and became operational in June 2015. A large portion of the detainee population comes from Central and South America. In 2015, 79% of the detainees admitted to the facility were from Central America (Mexico, El Salvador, Guatemala, Honduras, and Ecuador). The remainder of the population came from 114 countries. The NWDC is surrounded by a single perimeter fence. The vehicle entrance is controlled by accessing one of two gates. There is also a gate entrance for buses and vans transporting detainees in/out of the intake area. Entrance into the facility is controlled by a post at the main visitor entrance and a second key control entrance for facility staff.

There are administrative offices for both facility and ICE staff, a conference room, a physical fitness area, staff lockers, an armory, and control center in the front of the building. Access into the secure area of the facility is gained through the pedestrian sally port, controlled by the Master Center. Inside the facility there is a 438 foot main hallway providing access to the laundry, food service, visiting room, medical clinic, library and other program areas. There is a noncontact visiting area with private rooms for attorney visits. There are 18 male and 2 female housing pods contained within 17 housings units (labeled A-G) plus a segregation unit (H). 11 housing pods are all dormitory style, 5 are cell housing and 4 are a combination of cells and dorms. All cells are double celled except the segregation cells which are single. There is an intake booking area with holding cells, property storage, officer's station, and two health care/mental health rooms. All cells have a one piece sink and toilet, and there are community showers in all pods. Dorm style pods have group showers, sinks, and toilets. The medical holding cells all have an in-cell shower, toilet and sink. The facility also has three courtrooms within the secure perimeter that are utilized for deportation hearings.

ICE Health Services Corps Mission Statement -"IHSC is committed to providing health care services to reduce global disease and support the safe apprehension, enforcement and removal of detained individuals involved in immigration proceedings".

The Northwest Detention Center (NWDC) in Tacoma is the fourth largest such Immigration and Customs Enforcement, or ICE, detention facility in the country. The mission of the "NWDC is to provide conditions that are safe, secure and sanitary for detainees waiting processing for an administrative hearing or removal".

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D. Pre-Audit Meeting

On Sunday, September 24, 2017 the members of the audit team were transported from the Seattle-Tacoma International Airport to the Holiday Inn Express & Suites Tacoma Downtown by (b)(6); (b)(7)(C) Director, ACA Accreditation, Contract Compliance, GEO Group, Inc. The distance from the airport to the hotel was approx. 23.8 miles (54 minutes).

The audit team met briefly at the hotel on that evening to discuss the information provided by the Association staff and the officials from the Northwest Detention Center(IHSC). The chairperson divided the standards into the following groups:

Standards #HC 1A-01 to 3A-11 to (b)(6); (b)(7)(C)
Standards #HC 3A-12 to 7C-01 to

The audit team attended an "ice-breaker" dinner at the Shenanigans restaurant approximately from 06:00 PM to 07:50 PM that evening with Lowell Clark - Warden –

(b)(6); (b)(7)(C)

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ALDF audit team and other facility staffs. General conversation followed as the team member and the IHSC staff became acquainted, and general audit goals and procedures for the audit were discussed.

E. The Audit Process

1. Transportation

On Monday, September 25, 2017, the audit team was picked up from the hotel by (b)(6); (b)(7)(C) Director, ACA Accreditation, Contract Compliance, GEO Group, Inc. at 07:30 AM and arriving NWDC at 07:40 AM. The team followed the NWDC's security procedures.

2. Entrance Interview

The team was escorted to the main executive conference room by (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Director, ACA Accreditation, Contract Compliance (GEO Group) for a brief meeting with Warden Clark Lowell from 07:50 AM to 08:26 AM to express appreciation and explain the purpose of the audits. At 8:35 AM the audit team proceeded with the formal entrance meeting at the same conference room for a joint entrance audit meeting. The audit schedule and procedures were discussed, and the NWDC-IHSC staffs were asked about any problem areas of which the team should be aware. The NWDC-IHSC executive staffs were advised that the audit team would meet with them each evening prior to their departure from the facility to discuss the progress of the audit up to that point, and any problems that were encountered, and the audit team will attempt to review all the mandatory standards on the first day. Escorts were requested to accompany the auditors on the tour and subsequent visits to departments, and to note the number of detainees and the names and titles of employees with whom the auditors spoke.

The NWDC-IHSC staffs were asked if any detainee or employee had requested to speak with the auditors. No requests had been made. The audit chair expressed the team's appreciation and the appreciation of the ACA for the opportunity to be involved with the NWDC-IHSC audit in its re-accreditation process, and emphasized the goals of the accreditation, which are to improve the efficiency and effectiveness of correctional systems throughout the United States. The audit team was aware that the facility staff, especially the NWDC-IHSC staff had worked long and hard in preparation for this event, and accordingly the team would endeavor to provide a fair, equitable and thorough audit as possible while holding them accountable to high standards. The team members would visit as many departments and areas as possible relating to the audit and meet and speak with as many staff and detainees as possible in the time available, while at the same time strive to be as non-intrusive as possible.

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It was requested that when audit team members paused to speak with detainees, that staffs step away so that the conversation may remain private and the team would like to observe the practice in any medical emergency. The audit team reemphasized that the purpose of the audit is to be helpful and to assist the facility in achieving its re-accreditation. The entrance meeting lasted until 08:50 AM.

The following persons were in attendance:

(b)(6); (b)(7)(C)	Warden - NWDC Asst. Warden/Finance - NWDC Chief of Security - NWDC Compliance Administrator - NWDC HR Manager - NWDC Administrative Assistant - NWDC GEO Transport Incorporated Manager - NWDC Asst. Food Services Manager - NWDC Corporate Contract Compliance - GEO Asst. Field Office Director (AFOD) - ICE Detention Services Manager-ICE Acting Field Office Director (AFOD) - ICE Health Services Director – U.S Public Health Service (USPHS) Health Services Asst. Director - USPHS Health Services Asst. Director - USPHS ALDF ACA Auditor-Member ALDF ACA Auditor-Chair

3. Facility Tour

The team toured the medical area and other areas relating to the IHSC audit from 09:05 AM to 11:55 AM. ACA audit notices were posted throughout the facility. Staff and detainees were aware that an audit was taking place. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

(b)(6); (b)(7)(C)	Warden-Facility Compliance Administrator-Facility Corporate Contract Compliance - GEO Intake Officer Captain-Health Services Director –USPHS Officer-D2 Dorm Officer-D1 Dorm Officer-D1-Dorm Officer-Law Library Officer-Barber Shop

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(b)(6); (b)(7)(C)	Officer-Laundry Room Officer-Kitchen (Food Service) Officer-Recreation Yard Physician Assistant Medical Contractor-INGENESIS Officer-F4 Unit Lieutenant-H-SEG Officer-Master Control Officer-Master Control Officer-Master Control Facility Maintenance Major-Facility Business Manager/Asst. Warden Finance ALDF ACA Auditor-Member ALDF ACA Auditor-Chair

The following areas of the institution were visited and the following personnel and detainees were encountered during the course of the tour:

	(b)(6); (b)(7)(C)
Intake Medical D2 Dorm (Female) D1 Dorm (Female) Law Library Barber Shop Laundry Room Food Service F-4 Unit H-SEG Recreation Yard	

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

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Food Service:

Foodservices are provided by GEO Employees. Food service staffs includes (b)(7)(E) (b)(7)(E) (b)(7)(E) All meals provided are approved by a certified dietician and are nutritionally balanced, and are properly prepared. Meals are served in clean and safe surroundings. Detainees are provided three hot meals per day. There is no pork products served in this facility. Medical diets are provided by the Food Service Department upon receipt of written instructions from the facility Clinical Director. Meals are served in the day room of each housing units. Detainees in the Special Management Unit (SMU), SEG etc. are served in their cells. Meal schedules are breakfast at 05:30 AM, Lunch at 12:30 PM and Dinner at 05:30 PM. The audit team ate the detainee's dinner meal of applesauce, broccoli, white rice, hot dog (2), and hot dog buns and fruit punch on the first day of the audit. The food was well prepared, tasty and hot, and served in adequate portions.

The facility utilizes a "Diet for Health" menu and based on a six week menu cycle. Meals samples are kept for 72 hours. At the time of the audit, there were 160 medical diets. These diet orders contain both start and stop dates. These may be ordered anywhere from one day to length of stay. Diabetics on insulin have midnight snacks. Medical evaluations and screenings are done on detainee workers which monitored cuts/sores, burns, runny nose, nail condition and cold/flu symptoms. Detainees are allowed to handle food preparation. Refrigerators, freezers and the dry storage area were clean, orderly and clutter-free, and temperatures were in the appropriate ranges. The dishwasher was in proper working order, and documentation reflected temperatures in the appropriate range. Produce, milk and meat product are delivered twice per month. Expirations on food service products are carefully monitored.

Medical Care:

Medical services at the NWDC-IHSC are contracted through the INGENESIS. They also utilize Public Health Service (USPHS), Government Service (GS) staffing, Agency Nurses (Maxim Healthcare Services) and PRN's to provide medical, mental health and dental services. NWDC-IHSC medical receives detainees throughout the U.S and some with the history of high-risk behaviors, compounded by lack of medical care and /or mental health treatment, and are more likely to have chronic illnesses and infectious diseases. NWDC-IHSC is not an Intake/Diagnostic facility, but receives detainees off the street occasionally. The facility has a responsible physician (MD) and a Health Services Administrator (HSA). The working relationship between medical, mental health, program, dental and security are very remarkable. Medical staffs are well trained and caring professionals.

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Other accreditations for the NWDC-IHSC include National Commission on Correctional Health Care (NCCHC) and Performance Based National Detention Standards (ICE). The audit team observed the weekly (Tuesdays) agency shareholders meeting on the second day of the audit and found the meeting comprehensive and participatory. The meeting involved representatives from GEO Group, ICE, IHSC, Courts, CE's Office of the Principal Legal Advisor (OPLA), Contracting Officers Technical Representative (COR), Field Medical Coordinator (FMC) and Detention Services Manager (DSM). There are peer review evaluations and multidisciplinary team meetings.

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NWDC-IHSC medical has the followings:

- 2 AED's (secured and inspected)
- 1 EKG (secured and inspected, and read on site)
- 1 Fixed wall digital chest x-ray machine
- 1 Emergency bag (secured, inspected and sealed)
- 1 Secure administration medication room
- 1 Medication room
- 1 Pill window
- 4 Refrigerators (Flu, TB Solutions, etc.)
- 1 Refrigerator (Specimen)
- 4 Portable oxygen cylinders (secured and inspected by Airgas)
- 1 Oxygen concentrator (secured and inspected by Airgas)

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- 4 Negative pressure rooms (toilet and sink, and inspected 01/17/2017 by Air Management Solutions, Powder Springs, GA)
- 5 Suicide observation rooms (toilets and sinks)
- 2 Medical holding cells (toilets and sinks)

NWDC-IHSC has a Disability Placement Program (DPP) that provides for housing accessible lockers, bunk beds with grabs bars, accessible TTY phones, volume control phones, accessible dayroom tables and accessible path of travel. There are ample supplies of walking sticks, crutches and wheel chairs in the facility. Physical Therapy is provided through the St. Joseph's Outpatient Physical Therapy, Tacoma, WA.

NWDC-IHSC uses the following hospitals for inpatient hospitalization:

1. St. Joseph Medical Center, Tacoma, WA (local ER)
2. Tacoma General Hospital, Tacoma, WA

NWDC-IHSC has an agreement with the Tacoma Fire Department and EMS (4 minutes, 1.1 miles) in case of medical emergencies. Non-emergent medical transportation is done by facility staff to either a hospital facility or community provider for offsite consultations. The nurses have Basic Life Support (BLS) certified through the American Heart Association (AHA). Medical maintain basic TTA protocol medicine such as Epi pen, Narcan, Glucagon and etc. The Master SDS is maintained in medical. Officers are trained on first aid, CPR and AED, and are considered first responders. Upon admittance to the IHSC/NWDC, detainees receive a detainee handbook to aid in adjustment to detention setting. This documentation contains information regarding medical services, sick call process, grievance procedures and hygiene rules. Other methods are used to inform detainees about MRSA, AIDS, Hepatitis, and the spread of HIV, blood borne pathogens and safety. The audit team observed a medical emergency on the second day of the audit and medical responded within time.

Sick call is provided 7 days/week in General Population (GP), Special Management Unit (SMU) and SEG from 05:30 AM-until completed daily for males and females. The pod officer announces sick call and any detainee who wishes to come to sick call exits the dorm and reports to the intake area (F-Pod detainees report to the F-Medical office hallway) where they are triaged. The females are addressed first, then the males to ensure the populations are not mixed. In SEG, the detainees can sign up using a paper form, or verbally requesting of the RN doing SEG rounds at 0530 – 0600. Detainees sign up for sick calls at each housing unit electronically and in paper form. Detainees housed in SMU or SEG access all medical services via face to face encounters with an RN during daily rounds. Detainees housed in GP access all medical services via call out logs or electronic system.

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DHS-ICE-20-0618-A-001047

The average monthly sick calls are 708. The audit team observed sick call process in clinic and SMU on the second day of the audit and found the process well organized. Medical requests are triaged within 5 days, and any patient with symptoms is seen within one day. …." We do not have a medical Kite (request) system. All detainees are asked to come to sick call for any medical concern or request and are triaged at that time to determine the appropriate level of response/ care to provide. Any detainee who reports to sick call will be seen that same day.

There is no medical copay. No detainee is denied health care service. NWDC-IHSC uses detainee electronic medical records. Medical grievance is through the grievance box, collected by a grievance coordinator, and reviewed by the HSA within 7 days. Detainees have the option to submit a grievance using a paper form submitted through the medical grievance box outside of medical, or to use the electronic grievance system. Detainees are encouraged to use the electronic grievance system as it is sent directly to the medical grievance officer and received immediately upon submission. The system has a translation feature, so the detainee can write in the language most comfortable to them. The reply is sent straight to the detainee and the full communication is maintained in the database. The system creates an electronic log for accountability and tracking.

NWDC-IHSC averages six substantiated medical grievances per year mostly on medication preference, medication refills and time line to see a provider.

Services such as Physical Therapy, General Surgery, Cardiology, Dermatology, Endocrinology, Endodontist, Gastroenterology, Hematology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Orthopedic, OBGYN, Ophthalmology, Oncology, ENT, Podiatry, Pain Management, Urology, Pulmonary, Neuro Surgery, Plastic Surgery, Oral Surgery, Rheumatology, Optometry, Asthma and Allergy, Sleep Study are provided through off-site contracted specialists. The turnaround time to see an offsite contracted specialist is emergent-immediate, urgent 1-day and routine 14-days. There were no pregnant detainees or detainees on dialysis at the time of the audit. The number of chronic care detainees excluding mental health at the time of the audit was116. Males 50+ and females 40+ are provided with age specific annual medical examinations.

NWDC-IHSC has a plan for the management of communicable diseases including education on prevention, diagnosis, treatment and isolation. NWDC-IHSC has an infectious disease coordinator. NWDC-IHSC has four negative pressure rooms (5-beds). Infirmary services are provided at the St. Joseph's Medical Center, Tacoma, WA. MRSA precautions are in place. Universal precautions are practiced throughout the facility. There are available first aid and blood borne pathogen kits. There are eye wash stations present in appropriate areas. Hand sanitizers (non-alcohol) dispensers were located throughout medical and other areas. Sanitation and housekeeping is provided using detainee help. The total monthly TB tests are 404. An annual TB testing is conducted on all detainees after 12 months. NWDC-IHSC does not offer TB sticks only chest x-rays.

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Medications are stored in a medication room and secured behind double locks. A nurse administers medications three times a day and seven days a week in GP and SMU by direct observed therapy (DOT) at 08:00 AM, 12:50 PM and 08:00 PM for males and 08:30 AM, 01:15 PM and 07:30 PM (females). Prior to giving medications, detainee's identification is confirmed and mouth cavities checked after administration.

The audit team observed medication administrations in the GP and SMU, including diabetic line on the second day of the audit and found the process organized and timely. All no shows or refusal to medications are documented and /or referred. The HSA checks the electronic MARS record for missed doses. Keep on person medications are issued on 1:1 exchange. There are separate diabetic lines two times a day and seven days a week at 05:00 AM and 05:00 PM. At the time of the audit there were 67 diabetics (19-Insulin and 48 Non-insulin dependents). Insulin diabetic detainees receive mid-night snacks. Medical diets are coordinated with the food service. The audit team examined the manual during the audit and found it current. The manual is updated regularly by medical. There were 160 medical diets at the time of the audit. The average monthly detainees on prescription medications were 787, and controlled medications were 45. Some medications are crushed per doctor's order. Detainees are provided 30-day medications upon release. Per policy, detainees are provided a 7 day supply for most medications, those medication that policy states a 30 day supply should be given are filled as such. Additionally, the physician may request a 30 day supply be given upon release/deportation.

Specific Over-The-Counter (OTC) medications are offered at the Commissary, and reviewed and approved by the Clinical Director. NWDC-IHSC does not perform detoxification from alcohol, opiates hypnotics, other stimulants and sedative hypnotic drugs.. Detainees who come into our facility under the influence of alcohol or other substances are monitored and treated in accordance with National IHSC policy. Detainees determined to be experiencing severe withdrawal symptoms are referred to the local emergency room for assessment and treatment.

(b)(7)(E)

(b)(7)(E) Medications are ordered through McKesson Pharmacy. The backup pharmacy is the Diamond and a local Walgreen Pharmacy. Detainees are allowed keep-on-person (KOP) medications. The pharmacy is audited by the IHSC yearly, the HSA quarterly and internal audits. A random inventory count on sharps and controlled medications was accurate. The pharmacy has a refrigerator and a freezer for the storage of insulin, vaccines and ice packs. The audit team found the temperature log and inventory current. Basic medical supplies and materials are obtained through McKesson.

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The disposal of expired, unused, discontinued, recalled, over stocked medications including prescription, (pills and liquids) and narcotics are arranged through the Reverse Distributors. At the time of the audit there were medications awaiting disposal. Records are maintained on disposal process.

NWDC-IHSC medical has a draw only lab. Specimens are collected on site. Blood is spun and sent out for analysis to the LabCorp 5–days/week and reports received through fax/phone within 24-48 hours. STAT labs are also sent to the LabCorp and results received through fax/phone within 2-4 hours. Average monthly detainee lab tests are 924. Stericycle is contracted to pick up the biohazard and sharps wastes. The audit team checked the specimen refrigerator temperature log and found the records current. Chronic care patients receive annual screening test. Laboratory results are also incorporated into the EMR. NWDC-IHSC has a fixed wall stand digital chest x-ray machine. The X-ray department is supported by a fulltime contracted Radiology Technician (contract) through the XRAD Tele-Services and dosimetry by Pulse Imaging. All Intakes except transfers receive chest x-rays. Per IHSC policy , All Intakes except transfers (who have been in continuous ICE custody) ,with current chest x-rays, receive chest x-rays. Radiology services (MRI, Ultrasound, etc.) including STAT are provided through the St. Joseph's Medical Center Diagnostic Imaging, Tacoma, WA with results received in 2-48 hours by phone/fax.

(b)(7)(E)

(b)(7)(E) Dental services are provided from 05:30 AM - 05:00 PM (Monday-Friday). Dental services include basic dentistry, prophylaxis, fillings, partials, extractions, selected root canals, adjustment to existing dentures, cleaning, oral cancer screenings and patient education. The detainees access dental health services through the sick call process. The audit team reviewed the licenses, registrations, records and random inventory of sharps and instruments and found them accurate. The dental area was clean. Dental instruments and sharps not used at the year of expiration are re-autoclaved and repackaged.

The Dentist has a standing order; dental emergency outside the expertise of the nurse is referred to one of the contracted hospitals. The Dentist is notified. Dental at NWDC-IHSC is equipped with one (1) digital dental bitewing x-ray machine, two (2) dental chairs and one (1) Panorex digital x-ray machine. The dental wait time is less than 7 days. Urgent requests are seen within 24 hrs. The average monthly dental appointment is 343. Dental amalgam disposal is through WasteWise. Dosimeter reading is through PRS Dosimetry. Dental chair traps are cleaned weekly. Dental supplies are through Two Rivers Medical and dental equipment service, including dental compressor service is obtained through the Henry Schein. Broken tools are documented and disposed by facility maintenance.

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(b)(7)(E)

(b)(7)(E) They provide services 06:30 AM-08:00 PM (Mon-Fri) and 07:00 AM-03:30 PM (Sat) and on call. Daily rounds are conducted and detainees are evaluated every 30/60/90 days depending on needs. Detainees access mental health services via the sick call process. Staffs can refer services. There are approximately 428 detainees seen monthly. There were approximately 123 detainees on psychotropic medication at the time of the audit. All suicide ideations are referred to Mental Health and monitored, and observed 1:1. NWDC-IHSC has five suicide observation rooms. There are available suicide garments. NWDC-IHSC maintains zero tolerance for sexual abuse and harassment. Detainees are provided information on enhanced victim services and rape crisis hotline. Program services include crisis intervention, individual and group counseling and medication management. Severely developmentally and disabled detainees receive a mental health evaluation where appropriate and are referred for placement at the following inpatient psychiatric hospitals:

1. Greater Lakes Recovery Center, Tacoma, WA
2. Greater Lakes Evaluation and Treatment, Parkland, WA
3. Telecare Recovery Partnership, Lakewood, WA
4. Metropolitan Counsel Evaluation and Treatment Psychiatric Unit, Tacoma, WA
5. Recovery Innovation (leased space on the grounds of Western State Psychiatric Hospital, Tacoma, WA
6. Alvarado Parkway Institute, San Diego, CA

Laundry:

The audit team observed adequate supply of bed linens, pillows and blankets. Laundry process is done using mess bags. Bed linens, pillow cases and clothing are exchanged weekly and blankets are exchanged quarterly. Medical wastes are contained and washed separately using biohazard dissolving bags.

F. Examination of Records

Following the facility tour, the team proceeded to the medical conference room to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

The facility had no consent decrees, class action lawsuits or adverse judgments in the past year.

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2. Significant Incidents/Health Care Outcome Measures

The audit team reviewed the Significant Incident Summary and the Health Care Outcome Measures with the health care administrative team. During the audit period there were no deaths or serious medication errors. The audit team discussed the following sections on the Healthcare Outcome Measures for the audit period as follows:

1. Section 1A (9): Number of detainee with an active individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time was 213 in 2016-17, and with average detainee population of 1435. The NWDC-IHSC provided statement that the number suggested increase in better tracking and facility sometimes receives detainees off the street.
2. Section 3A (1): Number of detainee grievances related to health care services found in favor of the detainee in the past twelve (12) months was 6 in 2016-17, and with average number of evaluated grievances of 201. The NWDC-IHSC provided statement that grievances are due to detainees self-diagnosing and medication refills.

The values stated for the measures reflected a very busy facility with high transfer detainees from diverse population and age, with a wide variety of health concerns. The medical auditor concurs with the responses.

3. Departmental Visits

The team revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Intake	(b)(7)(E)
Medical	
D2 Dorm (Female)	

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D1 Dorm (Female)

Law Library
Barber Shop
Laundry Room
Food Service

Recreation Yard

(b)(7)(E)

4. Shifts

a. Day, Evening and Night Shifts

The audit team was present at the facility during the day, evening and night shifts from 05:57 AM to 05:45 PM on the first day of the audit. The team observed evening shift briefing from 07:15 AM-07:30 AM (3rd and 1st shifts) and 03:15 PM-03:30 PM (2nd shift). The briefing was mutual and participatory. Shift briefings are a normal occurrence. The shift supervisors passed on information to the oncoming shift. A familiar and easy rapport was evident among the staff, and information was freely exchanged. The audit team briefly introduced themselves and discussed the purpose of the audit and matters pertaining to the audit. The audit team observed diabetic line and spoke to 19 detainees (males and females) and 10 staffs, while the rest of the medical staff was busy taking care of the detainees and pleasant and professional.

5. Status of Previously Non-compliant Standards/Plans of Action

There were no standards previously found non-compliant.

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

There were no standards previously found non-compliant for which a waiver was not granted.

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

The audit team interviewed and spoke to approximately 124 detainees (males-63 and females-61) including the youngest and oldest of the males and females who stated that they generally felt secure at the facility and were treated fairly by staff.

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Their basic needs were being met and they felt that they were making positive progress towards eventual and successful release. They also felt that their basic medical needs were being met. They have ready access to sick call process and all were aware of the grievance process and the use of the 24 hr. card. Detainee morale appeared to be good and they were cooperative, respectful and were aware of the audit, and participated in the preparation for the audit. Notices of the ACA Accreditation process were observed to have been posted at different locations readily available to the detainees, and there were no detainees requested to speak privately with the audit team.

2. Staff Interviews

The audit team interviewed and spoke to approximately 51 employees, including 23 medical staffs, and observed them in the performance of their duties. The audit team observed structured medical shift change briefings. Staffs were polite, cooperative, and conducted themselves in a professional manner. There was a normal working relationship between medical, dental, mental health, programs and security, and communication flowed freely. Gender and ethnic diversity was good and morale also appeared to be good. Staff indicated that their training were excellent and are applicable to their positions and job needs.

H. Exit Discussion

The exit interview was held at 12:02 PM in the medical conference room with (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)

The chairperson explained the procedures that would follow the audit. The audit team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive to maintain their high level of professionalism in the correctional field.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Performance Based Health Care for Adult Correctional Institution, 1st Edition
Supplement	2014 Standards Supplement
Facility/Program	Northwest Detention Center (IHSC)
Audit Dates	September 25-26, 2017
Auditor(s)	(b)(6); (b)(7)(C) Audit Chairperson (b)(6); (b)(7)(C) Audit Member

	MANDATORY	NON-MANDATORY
Number of Standards in Manual	44	91
Number Not Applicable	0	12
Number Applicable	44	79
Number Non-Compliance	0	0
Number in Compliance	44	79
Percentage (%) of Compliance	100%	100%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps
Northwest Detention Center (IHSC)
Tacoma, Washington

September 25-26, 2017

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

STANDARD 1-HC-1A-02

WHEN MEDICAL CO-PAYMENT FEES ARE IMPOSED, THE PROGRAM ENSURES THAT, AT A MINIMUM, THE FOLLOWING ARE OBSERVED:

- ALL OFFENDERS ARE ADVISED, IN WRITING, AT THE TIME OF ADMISSION TO THE FACILITY OF THE GUIDELINES OF THE CO-PAYMENT PROGRAM
- NEEDED OFFENDER HEALTHCARE IS NOT DENIED DUE TO LACK OF AVAILABLE FUNDS
- CO-PAYMENT FEES SHALL BE WAIVED WHEN APPOINTMENTS OR SERVICES, INCLUDING FOLLOW UP APPOINTMENTS, ARE INITIATED BY MEDICAL STAFF

FINDINGS:

NWDC-IHSC does not charge detainees copay for any medical services to include pharmaceuticals dispensed by medical personnel.

STANDARD 1-HC-1A-21

ALL IN-TRANSIT OFFENDERS RECEIVE A HEALTH SCREENING BY HEALTH-TRAINED OR QUALIFIED HEALTH CARE PERSONNEL ON ENTRY INTO THE AGENCY SYSTEM. FINDINGS ARE RECORDED ON A SCREENING FORM THAT WILL ACCOMPANY THE OFFENDER TO ALL SUBSEQUENT FACILITIES UNTIL THE OFFENDER REACHES HIS OR HER FINAL DESTINATION. HEALTH SCREENS WILL BE REVIEWED AT EACH FACILITY BY HEALTH-TRAINED OR QUALIFIED HEALTH CARE PERSONNEL. PROCEDURES WILL BE IN PLACE FOR CONTINUITY OF CARE

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FINDINGS:

NWDC-IHSC does not process in-transit detainees.

STANDARD 1-HC-1A-34

OFFENDERS HAVE ACCESS TO A CHEMICAL DEPENDENCY TREATMENT PROGRAM. WHEN A CHEMICAL DEPENDENCY PROGRAM EXISTS, THE CLINICAL MANAGEMENT OF CHEMICALLY DEPENDENT OFFENDERS INCLUDES AT A MINIMUM THE FOLLOWING:

- A STANDARDIZED DIAGNOSTIC NEEDS ASSESSMENT ADMINISTERED TO DETERMINE THE EXTENT OF USE, ABUSE, DEPENDENCY, AND/OR CO-DEPENDENCY
- AN INDIVIDUALIZED TREATMENT PLAN DEVELOPED AND IMPLEMENTED BY A MULTI-DISCIPLINARY CLINICAL TEAM THAT INCLUDES MEDICAL, MENTAL HEALTH AND SUBSTANCE ABUSE PROFESSIONALS
- PRE-RELEASE RELAPSE-PREVENTION EDUCATION INCLUDING RISK MANAGEMENT
- THE OFFENDER WILL BE INVOLVED IN AFTERCARE DISCHARGE PLANS

FINDINGS:

NWDC-IHSC does not have a chemical dependency program.

STANDARD 1-HC-2A-04

WHEN INSTITUTIONS DO NOT HAVE QUALIFIED HEALTH CARE STAFF, HEALTH TRAINED PERSONNEL COORDINATE THE HEALTH DELIVERY SERVICES IN THE INSTITUTION UNDER THE JOINT SUPERVISION OF THE RESPONSIBLE HEALTH AUTHORITY AND WARDEN OR SUPERINTENDENT

FINDINGS:

NWDC-IHSC has a qualified health care staff to coordinate the health delivery services 24/7.

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DHS-ICE-20-0618-A-001057

STANDARD 1-HC-2A-16

IF VOLUNTEERS ARE UTILIZED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTION, TRAINING, STAFF SUPERVISON, FACILITY ORIENTATION, AND DEFINITION OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITY. VOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAINING. VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION

FINDINGS:

NWDC-IHSC does not use volunteers in the delivery of health care.

STANDARD 1-HC-2A-17

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION, COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A WRITTEN AGREEMENT BETWEEN FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS/INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

NWDC-IHSC does not use students, interns or detainees in the delivery of health care.

STANDARD 1-HC-2A-18

UNLESS PROHIBITED BY STATE LAW, OFFENDERS (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE THE FOLLOWING:

- PROVIDING PEER SUPPORT AND EDUCATION
- ENGAGING IN HOSPICE ACITIVITIES
- ASSISTING IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH
- ACTVITIES OF DAILY LIVING
- SERVING AS A SUICIDE COMPANION OR BUDDY IF QUALIFIED AND
- TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF A SUICIDE PREVENTION PLAN

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- HANDLING DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITIZING AND CLEANING, WHEN DIRECTLY SUPERVISED AND THEN IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES, WHILE IN A DENTAL ASSISTANCE TRAINING PROGRAM CERTIFIED BY THE STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY

OFFENDERS ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMING ACCESS OF OTHER OFFENDERS TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALTY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

NWDC-IHSC does not use detainees to perform familial duties.

STANDARD 1-HC-3A-10-1

IF TELE-HEALTH IS USED FOR PATIENT ENCOUNTERS, THE PLAN INCLUDES POLICIES FOR:

- PATIENT CONSENT
- CONFIDENTIALITY/PROTECTED HEALTH INFORMATION
- DOCUMENTATION
- INTEGRATION OF THE REPORT OF THE CONSULTATION INTO THE PRIMARY HEALTH CARE RECORD

FINDINGS:

NWDC-IHSC does not utilize telehealth

STANDARD 1-HC-7B-04

COMPENSATION AND BENEFIT LEVELS FOR ALL PERSONNEL ARE COMPARABLE TO SIMILAR OCCUPATIONAL GROUPS IN THE STATE OR REGION.

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FINDINGS:

NWDC-IHSC falls under the military pay grade.

STANDARD 1-HC-7C-01

THE PROGRAM PROVIDES FOR RECRUITING CITIZENS FOR INVOLVEMENT AND FOR VOLUNTEERS. THE SCREENING AND SELECTION OF VOLUNTEERS ALLOWS FOR RECRUITMENT FROM ALL CULTURAL AND SOCIOECONOMIC PARTS OF THE COMMUNITY.

FINDINGS:

NWDC-IHSC does not utilize volunteers.

STANDARD 1-HC-7C-02

EACH VOLUNTEER COMPLETES AN APPROPRIATE, DOCUMENTED ORIENTATION AND/OR TRAINING PROGRAM PRIOR TO ASSIGNMENT.

FINDINGS:

NWDC-IHSC does not utilize volunteers.

STANDARD 1-HC-7C-03

THERE IS AN OFFICIAL REGISTRATION AND IDENTIFICATION SYSTEM FOR VOLUNTEERS.

FINDINGS:

NWDC-IHSC does not utilize volunteers.

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DHS-ICE-20-0618-A-001060

Significant Incident Summary
This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Northwest Detention Center (IHSC) Reporting Period: 09/01/ 2016 – 08/31/2017

Incident Type	Months ⇨	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2017	June 2017	July 2017	Aug 2017	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender/ Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*														0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Northwest Detention Center (IHSC)
Tacoma, Washington
2017

		Health Care Outcomes		
Standard	**Outcome Measure**	**Numerator/Denominator**	**Value**	**Calculated O.M.**
1A	(1)	Number of offenders diagnosed with a MRSA infection within the past twelve (12) months	0	
	divided by	The average daily population	1435	0
	(2)	Number of offenders diagnosed with active tuberculosis in the past twelve (12) months	0	
	divided by	Average daily population.	1435	0
	(3)	Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months	0	
	divided by	Number of offenders administered tests for TB infection in the past twelve (12) months as part of periodic or clinically-based testing, but not intake screening.	15	0
	(4)	Number of offenders who completed treatment for latent tuberculosis infection in the past twelve (12) months	0	
	divided by	Number of offenders treated for latent tuberculosis infection in the past twelve (12) months.	0	0
	(5)	Number of offenders diagnosed with Hepatitis C viral infection at a given point in time	4	
	divided by	Total offender population at that time.	1435	0.002
	(6)	Number of offenders diagnosed with HIV infection at a given point in time	6	
	divided by	Total offender population at that time.	1435	0.004
	(7)	Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time	6	
	divided by	Total number of offenders diagnosed with HIV infection at that time.	6	1

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	(8)	Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less than 50 cps/ml	2	
	divided by	Total number of treated offenders with HIV infection that were reviewed.	6	0.33
	(9)	Number of offenders with an active individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time	213	
	divided by	Total offender population at that time.	1435	0.15
	(10)	Number of offender admissions to off-site hospitals in the past twelve (12) months	47	
	divided by	Average daily population.	1435	0.03
	(11)	Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months	106	
	divided by	Average daily population in the past twelve (12) months.	1435	0.07
	(12)	Number of offender specialty consults completed during the past twelve (12) months	1089	
	divided by	Number of specialty consults (on-site or off-site) ordered by primary health care practitioners in the past twelve (12) months.	1140	0.96
	(13)	Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mmHg/ >90 mm Hg	9	
	divided by	Total number of offenders with hypertension who were reviewed.	86	0.1
	(14)	Number of selected diabetic offenders at a given point in time who are under treatment for at least six months with a hemoglobin A1C level measuring greater than 9 percent	2	
	divided by	Total number of diabetic offenders who were reviewed.	20	0.1
	(15)	The number of completed dental treatment plans within the past twelve (12) months	174	
	divided by	The average daily population during the reporting period.	1435	0.12
2A	(1)	Number of health care ***staff*** with lapsed licensure or certification during a twelve (12) month period	2	
	divided by	Number of licensed or certified staff during a	62	0.03

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		twelve (12) month period.		
	(2)	Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job	21	
	divided by	Number of new health care staff during the twelve (12) month period.	23	0.91
	(3)	Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months	1	
	divided by	Number of employees.	62	0.02
	(4)	Number of direct care staff (employees and contractors) with a conversion of a TB test that indicates newly acquired TB infection in the past twelve (12) months	0	
	divided by	Number of direct care staff tested for TB infection in the past twelve (12) months during periodic or clinically indicated evaluations.	0	0
3A	(1)	Number of offender grievances related to health care services found in favor of the offender in the past twelve (12) months	6	
	divided by	Number of evaluated offender grievances related to health care services in the past twelve (12) months.	102	0.06
	(2)	Number of offender grievances related to safety or sanitation sustained during a twelve (12) month period	0	
	divided by	Number of evaluated offender grievances related to safety or sanitation during a twelve (12) month period.	0	0
	(3)	Number of adjudicated offender lawsuits related to the delivery of health care found in favor of the offender in the past twelve (12) months	0	
	divided by	Number of offender adjudicated lawsuits related to healthcare delivery in the past twelve (12) months	0	0
4A	(1)	Number of problems identified by quality assurance program that were corrected during a twelve (12) month period	6	
	divided by	Number of problems identified by quality assurance program during a twelve (12) month period.	6	1
	(2)	Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period.	4	
	(3)	Number of offender suicide attempts in the past	19	

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DHS-ICE-20-0618-A-001064

		twelve (12) months		
	divided by	Average daily population	1435	0.01
	(4)	Number of offender suicides in the past twelve (12) months	0	
	divided by	Average daily population	1435	0
	(5)	Number of unexpected natural deaths in the past twelve (12) months	0	
	divided by	Total number of deaths in the same reporting period.	0	0
	(6)	Number of serious medication errors in the past twelve (12) months	0	
5A	**None**			
6A	**None**			
7A	**None**			
7B	**None**			
7C	**None**			

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COMMISSION ON ACCREDITATION FOR CORRECTIONS
PANEL ACTION REPORT

Orlando World Center Marriott
Orlando, Florida

Saturday, January 6, 2018

Agency Name: ICE Health Service Corps (IHSC)
Facility Name: Northwest Detention Center (IHSC)
Facility Location: Tacoma, Washington

Agency Representatives: Jennifer Nussbaum, Warden

Panel Members: (b)(6); (b)(7)(C) Chairperson
(b)(6); (b)(7)(C)

Staff:

There were no panel actions.

Accreditation Panel Decision

Moved: Commissioner Bivens
Seconded: Commissioner Hill

Three-Year Accreditation: Yes

Accreditation Vote	**Yes**	**No**
Commissioner (b)(6); (b)(7)(C)	✓	
Commissioner	✓	
Commissioner	✓	
Commissioner	✓	

Final Tally

Mandatory	100%
Non-Mandatory	100%

AMERICAN OVERSIGHT

American Correctional Association

ACCREDITATION REPORT

Commission on Accreditation for Corrections

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

The mission of the Commission on Accreditation for Corrections is to upgrade and improve practices and conditions in adult and juvenile correctional facilities and programs through an accreditation process which is founded on a commitment to accountability, professionalism and respect for basic human rights and which recognizes sound and effective correctional practices, while striving towards excellence in the field of corrections.

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FOUNDED 1870

American Correctional Association

206 North Washington Street, Suite 200 • Alexandria, Virginia 22314
703 • 224 • 0000 Fax: 703 • 224 • 0010
www.aca.org

October 10, 2017

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

Congratulations!

It is a pleasure to officially inform you that the Port Isabel Service Processing Center (IHSC) was accredited by the Commission on Accreditation for Corrections at the American Correctional Association 2017 August Conference on August 21, 2017 in St. Louis, Missouri.

Your accreditation represents the satisfactory completion of a rigorous self-evaluation, followed by an outside review by a team of experienced, independent auditors.

Every profession strives to provide a high quality of service to society. To know that you, your staff, and other officials are complying with the requirements of the accreditation process is indeed a statement of a high level of commitment to the staff and persons under your care.

On behalf of the American Correctional Association and the Commission on Accreditation for Corrections, thank you for your commitment to the corrections profession and to the accreditation process.

Sincerely,

Denise M. Robinson

Denise Robinson, Chairperson
Commission on Accreditation for Corrections

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For Immediate Release

Port Isabel Service Processing Center (IHSC) Awarded National Accreditation

Denise Robinson, Chairperson of the Commission on Accreditation for Corrections (CAC), and Bridget Bayliss-Curren, Director of Standards and Accreditation, American Correctional Association recently announced the accreditation of the Port Isabel Service Processing Center (IHSC). The award was presented in conjunction with the American Correctional Association 2017 Summer Conference on August 21, 2017 in St. Louis, Missouri.

In presenting the award, Denise Robinson, Chairperson of the CAC, and Lannette Linthicum, President of the American Correctional Association (ACA), complimented the facility on their professional level of operation and their success in completing the accreditation process. The agency is one of over 1,500 correctional organizations currently involved in accreditation across the nation.

The accreditation program is a professional peer review process based on national standards that have evolved since the founding of the Association in 1870. The standards were developed by national leaders from the field of corrections, law, architecture, health care, and other groups who are interested in sound correctional management.

ACA standards address services, programs, health care and security operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for agencies and facilities throughout the world.

The three-year accreditation award granted to the Port Isabel Service Processing Center (IHSC) does not signal the end of their involvement in the accreditation process. During the award period, staff will work to improve any deficiencies identified during the audit and maintain continuous compliance with the standards.

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AMERICAN CORRECTIONAL ASSOCIATION

206 NORTH WASHINGTON STREET, SUITE 200 • ALEXANDRIA, VIRGINIA 22314
703 • 224 • 0000 FAX: 703 • 224 • 0010
WWW.ACA.ORG

Congratulations on your accreditation award! You are now a member of the elite in achieving correctional excellence. The certificate you have received is but a small symbol of the enormous dedication and commitment demonstrated by each and every member of your staff to the accreditation process, and I urge you to display it prominently as a continual reminder of the level of professionalism achieved. This is just the beginning of your journey, however, for the true test of excellence is the test of time. It is critical that your operation be able to sustain this achievement over time and be constant through both prosperity and adversity.

Achieving American Correctional Association Accreditation means you have demonstrated your dedication to getting the job done right, and that you are holding your agency to a higher standard.

Thank you for your commitment to the American Correctional Association and the standards and accreditation process.

Bridget Bayliss Curren

Bridget Bayliss-Curren, Director
Standards and Accreditation
American Correctional Association

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DHS-ICE-20-0618-A-001070

Overview of the American Correctional Association

The American Correctional Association is the oldest and most prestigious correctional membership organization in the United States. Founded in 1870, ACA currently represents more than 20,000 correctional practitioners in the United States and Canada. Members include all levels of staff from a wide variety of correctional disciplines and programs as well as professionals in allied fields and representatives from the general public. In addition, the Association represents the interests of 74 affiliated organizations whose goals, while similar to those of ACA, focus on specialized fields and concerns within the realm of corrections.

At its first organizational meeting held in Cincinnati, Ohio, in 1870, the Association elected then-Ohio governor and future U.S. President, Rutherford B. Hayes, as its first president. The *Declaration of Principles* developed at that first meeting became the guidelines for correctional goals in both the United States and Europe.

Since that time, ACA has continued to take a leadership role in corrections and work toward a unified voice in correctional policy. In recent years, one of the Association's major goals has been the development of national correctional policies and resolutions of significant issues in corrections. These policies are considered for ratification at the Association's two annual conferences and ratified policies are then disseminated to the field and other interested groups. ACA has also had a major role in designing and implementing professional standards for correctional practices, as well as methods for measuring compliance with those standards.

The Association conducts research and evaluation activities, provides training and technical assistance, and carries out the regular responsibilities of any professional membership organization, including a full publications program. The Association's two annual conferences, held in varying cities across the nation, attract more than 5,000 delegates and participants each year from the 50 states, U.S. territories, and several foreign countries.

Membership in ACA is open to any individual, agency, or organization interested in the improvement of corrections and the purposes and objectives of the Association. Members include the majority of state, local, provincial, and territorial correctional agencies; individual correctional institutions and local jails, pretrial programs and agencies, schools of criminal justice in colleges and universities, libraries; and various probation, parole, and correctional agencies. Most of ACA's members are employed at the federal, state, and local levels. Members also include more than 200 volunteers affiliated with these agencies as administrators or as members of advisory boards and committees.

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Organizational Purposes of the American Correctional Association

Among the most significant purposes of the Association as outlined in its Constitution, are:

To promote the coordination of correctional organizations, agencies, programs, and services to reduce fragmentation and duplication of effort and increase the efficiency of correctional services on a national basis.

To develop and maintain liaisons and a close working relationship in America with national, regional, state, and local associations and agencies in the correctional, criminal justice, civic, and related fields for mutual assistance and the interchange of ideas and information, and to extend and strengthen cooperative working relationships with similar associations and agencies on the international level.

To develop and promote effective standards for the care, custody, training, and treatment of offenders in all age groups and all areas of the correctional field: detention facilities and services, institutions and other facilities for juvenile and adult offenders, probation, parole, community residential centers, and other community-based programs and services.

To conduct studies, surveys, and program evaluations in the correctional field, and provide technical assistance to correctional organizations, departments, institutions, and services.

To publish and distribute journals and other professional materials dealing with all types of correctional activities.

To promote the professional development of correctional staff at all levels.

In carrying out these purposes, ACA sponsors programs for policy analysis, demonstration, and research. ACA also provides testimony, consultation, publications, conferences, workshops, and other activities designed to stimulate constructive action regarding correctional problems.

Standard and Accreditation

Perhaps ACA'S greatest influence has been the development of national standards and the accreditation process. ACA standards address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for over 1,500 correctional agencies in the United States.

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Organizational Structure of the American Correctional Association

Executive Committee

The Executive Committee is composed of the elected officers of the Association - president, vice president, treasurer, two Board of Governors' members, the immediate past president, the president-elect, and the ACA executive director. The Executive Committee meets at least quarterly and exercises most of the powers of the Board of Governors during the intervals between meetings of the board.

Board of Governors

ACA's bylaws vest control of the Association with an 18-member elected Board of Governors composed of the officers of the Association and five at-large members. To ensure the interdisciplinary nature of the Association, board members must represent the following areas:

At-Large Citizen (not employed in corrections)
Correctional Administration (Adult)
Correctional Administration (Juvenile)
Institutions (Adult)
Institutions (Juvenile)
Probation (Adult)
Probation (Juvenile)
Parole or Post-Release Supervision (Adult)
Community Programs (Adult)
Community Programs (Juvenile)
Aftercare or Post-Release Supervision (Juvenile)
Detention (Adult)
Detention (Juvenile)
At-Large (Ethnic Minority) (3)
Education
Member At-Large

Delegate Assembly

The Delegate Assembly is composed of delegates from the professional affiliates, geographical chapters, membership at-large, Board of Governors, past presidents of ACA, and representatives of each military service. The Delegate Assembly can establish policy, define Association positions on broad social and professional issues, and determine major programs and legislative priorities. They meet at least twice annually, at the Winter Conference and Congress of Correction.

Committees

The majority of the Association's activities take place through committees. Each committee chair reports to the Association's Board of Governors at least twice a year. In this way, the Association collectively benefits from the involvement and contribution of the hundreds of individuals who function on the various committees. Ad-hoc committees are appointed by the president of the Association.

The current committees and councils are:

Committee on Affirmative Action
Committee on Constitution and Bylaws

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Committee on International Relations
Committee on Congress Program Planning
Committee on Legal Issues
Committee on Correctional Awards
Committee on Membership
Committee on Military Affairs
Council of Professional Affiliates
Council of Dual-Membership Chapters and State and Geographical Affiliates
Nominating Committee
Council on Professional Education
Credentials Committee
Research Council
Eligibility Committee
Resolutions & Policy Development Comm
Committee on Ethics
Standards Committee
Legislative Affairs Committee

Affiliates and Chapters

Affiliates and state chapters are major features of the Association's structure. They represent professional, regional, and state groups across the United States and Canada. Affiliates and chapters contribute to the professional development of all members by providing consultation in their respective areas of interest and by participating in seminars and workshops at ACA's annual conferences.

The following affiliates and chapters are currently associated with ACA:

Alabama Council on Crime and Delinquency
Alston Wilkes Society
American Assn for Correctional Psychology
American Correctional Chaplains Association
American Correctional Food Service Association
American Correctional Health Services Assn
American Institute of Architects
American Jail Association
American Probation and Parole Association
Arizona Probation, Parole, and Corrs Assn
Association for Corrl Research and Info Mgmt
Assn of Paroling Authorities, International
Assn of State Correctional Administrators
Assn of Women Executives in Corrections
International Assn of Correctional Officers
Iowa Corrections Association
Juvenile Justice Trainers Association
Kansas Correctional Association
Kentucky Council on Crime and Delinquency
Louisiana Correctional Association
Maryland Criminal Justice Association
Michigan Corrections Association
Middle Atlantic States Correctional Association
Minnesota Corrections Association
Missouri Corrections Association
National Association of Adult and Juvenile State
Corrections Mental Health Directors
National Assn of Blacks in Criminal Justice
National Association of Juvenile Corrl Agencies
Oregon Criminal Justice Association
Parole and Probation Compact Administrators Association
Pennsylvania Assn of Probation, Parole, and Corrections
Prison Fellowship
South Carolina Correctional Association
Tennessee Corrections Association
Association on Programs for Female Offenders
Central States Correctional Association
Colorado Correctional Association
Connecticut Criminal Justice Association
Correctional Association of Massachusetts
Correctional Accreditation Managers Assn
Correctional Education Association
Correctional Industries Association
Family and Corrections Network
Florida Council on Crime and Delinquency
Illinois Correctional Association
Indiana Correctional Association

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International Assn of Corrl Training Personnel
International Community Corrections Assn
National Association of Probation Executives
National Coalition for Mental and Substance Abuse Health Care in the Justice System
National Correctional Recreation Association
National Council on Crime and Delinquency
Nation Juvenile Detention Association
Nebraska Correctional Association
Nevada Correctional Association
New Jersey Chapter Association
New Mexico Correctional Association
New York Corrections and Youth Svcs Assn
North American Association of Wardens & Superintendents
North Carolina Correctional Association
Ohio Correctional and Court Svcs Association
Texas Corrections Association
The Salvation Army
Utah Correctional Association
Virginia Correctional Association
Volunteers of America
Washington Correctional Association
Wisconsin Correctional Association

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Major Activities of the American Correctional Association

Legislation

The American Correctional Association is involved with all major issues affecting corrections today. Members and ACA staff maintain close working relationships with committees of the U.S. Congress and all federal agencies and groups whose decisions affect correctional policy. Expert testimony on a wide range of correctional issues is prepared for congressional committee and subcommittee hearings, and recommendations are provided to federal administrative agencies.

To ensure that the concerns and issues of the corrections profession are represented in proposed legislation and public policy, ACA's legislative liaison is addressing legislative and government concerns that will impact the corrections profession. ACA has established partnerships between chapters and affiliates and other national policy making organizations to present a strong collective voice for correctional reform throughout the world.

Professional Development

The purpose of the Association's Professional Development Department is to plan, promote, and coordinate professional development through training seminars, workshops, and published materials including curriculums, resource guides, and monographs.

ACA's training plan calls for a variety of professional development activities. Nationally advertised workshops cover topics such as training for trainers, management training, community-based employment programs, and stress management. On-site workshops for state and local departments of corrections are offered in curriculum development, supervision, communications, and report-writing skills.

The *Training for Correctional Staff Trainers* workshops further the skills of correctional professionals qualified to initiate and deliver training. These workshops also enable agencies to comply with national standards for accreditation and ensure that training is job-related and professionally developed and presented.

The department also offers correspondence courses to further professional development. More than 6,000 correctional personnel have completed or are in the process of completing ACA's self-instruction training program for correctional officers. This program, developed under the auspices of the National Institute of Corrections, provides 40 hours of basic training in accordance with ACA standards. A score of at least 80 percent on the comprehensive examination must be attained to achieve certification.

The Association has similar courses available for correctional supervisors, juvenile caseworkers, and food service employees. Additional courses which cover report writing skills, correctional management skills, legal issues for probation and parole officers, and legal issues for correctional officers are also available.

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Publications

As one of the leading publishers of practical correctional publications, ACA produces books, videos, and lesson plans. Among the wide ranging subjects available are management, community, security, counseling, law, history, and health. These excellent resources for career advancement appeal to practitioners and scholars alike. Directories for every major sector of corrections are also published by ACA.

The following is just a few of the many publications that ACA offers:

Corrections Today is the major corrections magazine in the United States. Published seven times a year, it focuses on the interests of the professional correctional employee and administrator. Articles include reports of original research, experiences from the field, discussion of public policy, and the perspectives of prominent practitioners and academicians.

On the Line is published five times a year and contains national and local news of interest to the criminal justice professional.

Corrections Compendium Newsletter publishes cutting-edge information about the corrections environment. Survey information is compiled from 52 U.S. and 14 Canadian correctional systems.

The Juvenile and Adult Directory has been published since 1939. A revised edition of the directory is released each January. This publication is the only up-to-date, comprehensive directory of all U.S. and Canadian juvenile and adult correctional departments, institutions, agencies, and paroling authorities.

The National Jail and Adult Detention Directory was first published in 1978. It is a source of information concerning jails. The directory, published every two years, attempts to list all jails in the United States that house offenders or detainees for more than 48 hours.

The Probation and Parole Directory, updated every two years, provides over 500 pages of information regarding federal, state, and county adult and juvenile probation, parole and aftercare systems in the United States. It includes statistics on caseloads, expenditures, and personnel.

The State of Corrections, formerly *The Proceedings*, includes the events of both the Congress of Correction and the Winter Conference. Published since 1870, it includes selected speeches and panel presentations concerning the latest thoughts and practices in the criminal justice field.

Correctional standards are the most significant improvement in correctional programming. As the basis for accreditation, they give administrators a nationally recognized system for upgrading and improving their correctional services. The Association currently publishes over 20 manuals for every correctional discipline.

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To aid in the development of policy with relation to accreditation, *Guidelines for the Development of Policies and Procedures* are available for adult correctional institutions, adult parole authorities/adult probation and parole field services, adult local detention facilities, adult community residential services, juvenile detention facilities, and juvenile training schools.

Conventions

ACA hosts two national conventions each year that attract more than 5,000 professionals from all aspects of corrections; the Winter Conference held in January, and the Congress of Correction, held in August. These events include a variety of workshops, exhibits, and seminars devoted to addressing topics specific to the corrections profession.

Contracts and Grants

The American Correctional Association has a history of successful grant and contract management and administration. ACA has completed contracts and grants of more than $30 million. These diverse initiatives, which are funded through federal and private sources, add to the technical expertise and knowledge of the organization as well as to the total field of corrections.

Standards and Accreditation

Perhaps ACA's greatest influence has been the development of national standards and the accreditation process. ACA standards address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for over 1,200 correctional agencies in the United States.

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Overview of the Commission on Accreditation for Corrections

The Commission on Accreditation for Corrections (CAC) is a private, nonprofit organization established in 1974 with the dual purpose of developing comprehensive, national standards for corrections and implementing a voluntary program of accreditation to measure compliance with those standards.

The Commission was originally developed as part of the American Correctional Association. In 1979, by joint agreement, the Commission separated from the Association in order to independently administer the accreditation program. Between 1978 and 1986, the organizations shared the responsibility for developing and approving standards and electing members of the Commission. On November 7, 1986, the Commission on Accreditation for Corrections officially realigned itself with the American Correctional Association.

The Commission meets at least twice each year. The responsibility of rendering accreditation decisions rests solely with this board. The members of the Commission represent the full range of adult and juvenile corrections and the criminal justice system. They are elected from the following categories:

National Association of Juvenile Correctional Agencies (1 representative)
Council of Juvenile Correctional Administrators (1 representative)
Association of State Correctional Administrators (2 representatives)
National Sheriffs' Association (2 representatives)
American Jail Association (1 representative)
North American Association of Wardens and Superintendents (1 representative)
International Community Corrections Association (1 representative)
American Probation and Parole Association (1 representative)
Association of Paroling Authorities International (1 representative)
National Juvenile Detention Association (1 representative)
American Bar Association (1 representative)
American Institute of Architects (1 representative)
National Association of Counties (1 representative)
Correctional Health (Physician) (1 representative)
Juvenile Probation/Aftercare (1 representative)
Adult Probation/Parole (1 representative)
At-Large (17 representatives)
Citizen At-Large (Not in Corrections) (1 representative)

Association Staff

Accreditation activities are supported by the staff of the American Correctional Association, Standards and Accreditation Department, under the leadership of the director of the department. Standards and Accreditation Department staff is responsible for the daily operation of the accreditation program. Agencies in the process have contact primarily with the accreditation specialist responsible for their state or agency.

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Auditors

Over 600 corrections professionals in the United States have been selected, trained, and employed on a contract basis by the Association. These individuals perform the field work for the Association which includes providing assistance to agencies working toward accreditation, conducting on-site audits of agencies to assess compliance with standards and confirming that requirements are met, and monitoring to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to visiting committees or audit teams, are formed to conduct standards compliance audits of agencies seeking accreditation and reaccreditation.

Auditors are recruited nationally through announcements in prominent criminal justice publications and at major correctional meetings. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All auditors employed by the Association have a minimum of three years of responsible management experience, have received a recommendation from an agency administrator, and have demonstrated knowledge in the substantive area(s) in which they are employed to assist the Association. In addition, all auditors must successfully complete the Association's auditor training and be members of the ACA in good standing.

Standards Development

Development of the ACA standards began in 1974 with an extensive program of drafting, field testing, revising, and approving standards for application to all areas of corrections. Since then, over 1,200 correctional facilities and programs have adopted the standards for implementation through accreditation, and many others have applied the standards informally themselves.

In the development of standards, the goal was to prescribe the best possible practices that could be achieved in the United States today, while being both realistic and practical. Steps were taken to ensure that the standards would be representative of past standards development efforts, reflect the best judgment of corrections professionals regarding good corrections practice, recognize current case law, and be clear, relevant, and comprehensive. The standards development and approval process has involved participation by a wide range of concerned individuals and organizations. Twenty-three manuals of standards are now used in the accreditation process:

Standards for the Administration of Correctional Agencies
Standards for Adult Parole Authorities
Standards for Adult Probation and Parole Field Services
Standards for Adult Correctional Institutions
Standards for Adult Local Detention Facilities
Standards for Small Jail Facilities
Standards for Electronic Monitoring Programs
Standards for Adult Community Residential Services
Standards for Adult Correctional Boot Camps
Standards for Correctional Industries
Standards for Core Jails

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Standards for Correctional Training Academies
Standards for Juvenile Community Residential Facilities
Standards for Correctional Facilities
Standards for Juvenile Detention Facilities
Standards for Juvenile Day Treatment Programs
Standards for Juvenile Correctional Boot Camps
Standards for Therapeutic Communities
Standards for Small Juvenile Detention Facilities
Standards for Performance-Based Health Care in Adult Correctional Institutions
Certification Standards for Health Care Programs
Standards for Adult Correctional Institutions (in Spanish)

The standards establish clear goals and objectives critical to the provision of constitutional and humane correctional programs and services. The standards include the requirement for practices to promote sound administration and fiscal controls, an adequate physical plant, adherence to legal criteria and provision of basic services. Basic services called for by the standards include the establishment of a functional physical plant, training of staff, adoption of sanitation and safety minimums, and provision of a safe and secure living environment. In offering specific guidelines for facility and program operations, the manuals of standards address due process and discipline, including access to the courts, mail and visitation, searches, and conditions of confinement of special management offenders.

The standards are systematically revised to keep pace with the evolution of different correctional practices, case law, and after careful examination of experiences, applying them over a period of time and circumstances. The ACA Standards Committee, which includes membership from the Commission on Accreditation for Corrections, is responsible for standards development and revision.

The ACA publishes biannual supplement to the standards with updated information and clarifications until new editions of standards manuals are published. Each supplement addresses standards interpretations, deletions, revisions, and additions for all manuals of standards issued by the Standards and Accreditation Department.

Suggestions and proposals for revisions to the standards from the field and interested others are encouraged. The Standards and Accreditation Department has developed a standards proposal form specifically for this purpose. The standards proposal form can be obtained from the Standards Supplement, the ACA website, or Standards and Accreditation Department staff (Appendix A). Proposals should be submitted via the ACA website.

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Accreditation Process Descriptions

For over 120 years, the American Correctional Association has been the only national body involved in the development of standards for the correctional field. ACA standards are supported by ACA's Standards and Accreditation Department and the Commission on Accreditation for Corrections, which is the evaluating and certifying body for accreditation. The department is responsible for the administration of accreditation and ongoing development of correctional standards.

The accreditation process is a voluntary program for all types of correctional agencies. For these agencies, accreditation offers the opportunity to evaluate their operations against national standards, to remedy deficiencies, and to upgrade the quality of programs and services. The recognized benefits of such a process include: improved management; a defense against lawsuits through documentation; demonstration of a "good faith" effort to improve conditions of confinement; increased accountability and enhanced public credibility for administrative and line staff; a safer and more humane environment for personnel and offenders; and the establishment of measurable criteria for upgrading programs, staffing, and physical plant on a continuous basis.

A major component of the accreditation process is the standards compliance audit conducted by a visiting committee. The purpose of the audit is to measure operations against the standards, based on documentation provided by the agency.

The Visiting Committee Report

The results of the standards compliance audit are contained in the visiting committee report, a document prepared by the visiting committee chairperson. The report is distributed to the agency administrator and members of the visiting committee. This report is also submitted to the Commission on Accreditation for Corrections for consideration at the accreditation hearing.

The following information is usually contained in the visiting committee report:

Agency and Audit Narrative

The agency narrative includes a description of program services, a description of physical plant, number of offenders served on the days of the audit, a summary significant incidents and consent decrees, class action lawsuits and/or judgments against the agency/facility, if applicable. The audit narrative, prepared by the visiting committee chairperson, describes audit activities and findings. The narrative examines issues or concerns that may affect the quality of life and services in an agency or facility. Quality of life issues include areas such as staff training, adequacy of medical service, sanitation, use of segregation and detention, reported and/or documented incidences of violence and crowding in institutions, offender activity levels, programming and provision of basic services. The audit narrative also contains comments as a result of staff and offender interviews, and a detailed explanation of all noncompliant and not applicable standards.

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Agency Response

The agency has three options for standards found in noncompliance: a plan of action; an appeal; or a waiver request.

A **plan of action** is a detailed statement of tasks to be performed in order to achieve compliance with a standard found in noncompliance at the time of the audit. The plan of action designates staff responsibilities and timetables for completion.

An **appeal** is the agency's attempt to change the visiting committee's decision on a standard. The result of a successful appeal is a change in the status of the standard and a recalculation of the compliance tally.

A **waiver** may be requested when noncompliance with a standard does not adversely affect the life, health, or safety of staff and offenders and when quality of life conditions compensate for the lack of implementation of a plan of action. The granting of a waiver by the Commission waives the requirement for submitting a plan of action; however, it does not change the noncompliant finding.

A **discretionary compliance request** is when there are circumstances in which agencies choose not to comply with a particular standard for a variety of reasons. These reasons include:

- An unwillingness to request funds from a parent agency or funding source.
- A preference to satisfy the standard/expected practice's intent in an alternative fashion.
- An objection from a parent agency, higher level government official or funding source to the nature of the standard/expected practice.
- A clear policy in place at a higher level that is contrary to the requirements of the standard/expected practice.
- An existing provision in a collective bargaining agreement that makes compliance impossible (without bargaining with the employees' union to effect such a change).

Auditor's Response

This section contains the visiting committee's final reply to all responses received from the agency and includes comments regarding the acceptability of plans of action, appeals, and waivers.

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Accreditation Hearings

The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers an agency's application at its next regular meeting following completion of the visiting committee report. The Commission is divided into panels that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include a quorum of at least three Commissioners which includes the panel hearing chairperson. Agencies are notified in writing of the date, time, and location of the hearings by Standards and Accreditation Department Staff.

The panel hearing is the last step in the process. With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented during the hearing and in the visiting committee report is considered by the panel members in rendering accreditation decisions.

The agency is invited to have a representative at the hearing and, in most cases, one or more individuals attend. When special conditions warrant, the visiting committee chairperson or a member of the visiting committee also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) occurs only with the permission of the applicant agency. In these cases, the applicant agency representatives and panel members discuss procedures to be followed before commencement of the hearing.

Conduct of Hearings

The panel schedule provides ample time for review of each individual agency pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures. Panel proceedings require that a formal vote be taken on all final actions, i.e., agency appeals, waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- Applicant agency representatives are requested by Standards and Accreditation Department staff to be on-call to allow for scheduling flexibility.
- A designated waiting area is usually provided for this purpose.
- When the panel is ready to review the agency, the Standards and Accreditation Department staff representative notifies agency representative(s).
- The hearing opens with an introduction by the panel chairperson.
- The agency representative is asked to give a brief description of the

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program.

- If a visiting committee member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the visiting committee member only to request additional information at different points during the hearing.

- The panel chairperson leads a standard by standard review of non-compliance issues. The agency representative presents information relative to their request for waivers, plans of action, appeals, and discretionary compliance requests. The agency may also present additional materials, including photographs or documentation, for review by the panel.

- Following the agency presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of agency personnel or in executive session varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

In final deliberations, the Commission panel:

- Ensures compliance with all mandatory standards and at least 90 percent of all other standards.

- Responds with a formal vote to all appeals submitted by the applicant agency.

- Responds with a formal vote to all request for waivers, discretionary compliance, and plans of action submitted by the applicant agency.

At this time, the panel also:

- Assures that an acceptable plan of action will be submitted for every non-compliant standard, including those standards for which appeals of non-compliance and waiver requests have been denied by the panel. In judging the acceptability of plans of action, the panel ensures that all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.

- Addresses to its satisfaction any concerns it has with visiting committee comments about the quality of life in the facility or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to

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the life, health, and safety of residents and staff.

For each application, a roll call vote to award accreditation, extend an agency in Candidate or Correspondent Status, or deny accreditation is conducted. The options for final action available to the panel are outlined in the next chapter.

If the panel has deliberated in executive session, agency representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant. If accreditation has not been granted, the chairperson discusses with agency personnel specific reasons for the decision and the conditions of extension in Candidate or Correspondent Status and procedures for appeal.

Accreditation Decisions

Three decisions relative to the accreditation of an agency are available to panels:

- *Three-year accreditation award* based on sufficient compliance with standards, acceptance of adequate plans of action for all non-compliant standards and satisfaction of any other life, health, and safety conditions established by the panel. The balance of the contract must be paid in full in order to receive a certificate of accreditation.

- *Extension of the applicant agency in Candidate Status* (initial accreditation only) for reasons of insufficient standards compliance, inadequate plans of action, or failure to meet other requirements as determined by the panel. The Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the facility or program that adversely affect the life, health, or safety of the offenders or staff. Extension of an applicant in Candidate Status is for period of time specified by the panel and for identified deficiencies if in the panel's judgment, the agency is actively pursuing compliance.

- *Probationary Status* is determined when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are quality of life issues that would indicate continued monitoring. While an award of accreditation is granted, a monitoring visit must be completed and the report presented at the next meeting of the Commission. The cost for a monitoring visit is borne by the agency at a rate of cost plus 25%. The agency does not have to appear before the Commission for the review of the monitoring visit report. If they choose to do so, all related travel expenses are borne by the agency. Specific expectations for removal from probation are outlined.

- *Denial of accreditation* removes the agency from Accredited Status (in the case of reaccreditation) and withdraws the agency from the accreditation program. Situations such as insufficient standards compliance, inadequate plans of action, failure to meet other requirements as determined by the panel or quality of life issues may lead to the denial of accreditation, it is

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withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing. The Commission will explain the process for appeal.

The agency receives written notification of all decisions relative to accreditation after the hearing.

Appeal Process

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status. Therefore, an agency may submit an appeal of any denial or withdrawal of accreditation.

The basis for reconsideration is based on grounds that the decision(s) were:

- Arbitrary, capricious, or otherwise in substantial disregard of the criteria and/or procedures promulgated by the Commission.
- Based on incorrect facts or an incorrect interpretation of facts.
- Unsupported by substantial evidence.
- Based on information that is no longer accurate.

The reasonableness of the standards, criteria, and/or procedures for the process may not serve as the basis for reconsideration. The procedures for reconsideration are as follows:

- The agency submits written request for reconsideration to the Director of Standards within 30 days of the adverse decision stating the basis for the request.
- The Executive Committee of the Commission, composed of the officers of the Commission, reviews the request and decides whether or not the agency's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The agency is notified in writing of the Executive Committee's decision.
- If the decision is made to conduct a hearing, the hearing is scheduled for the next full Commission meeting and the agency is notified of the date.
- The agency, at its option and expense, has the right of representation, including counsel.
- Following the hearing held before the Commission, the decision, reflecting a majority opinion, is made known to the agency immediately.
- Pending completion of the reconsideration process, the agency maintains its

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prior status. Until a final decision has been reached, all public statements concerning the agency's accredited status are withheld.

- Following completion of the reconsideration process, any change in the status of an agency is reflected in the next regularly published list of accredited agencies.

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Accredited Status

The accreditation period is three years, during which time the agency must maintain the level of standards compliance achieved during the audit and work towards compliance of those standards found in non-compliance. Regular contact with Standards and Accreditation Department staff should also be maintained.

Annual Report

During the three year accreditation period, the agency submits an annual report to the Standards and Accreditation Department. This statement is due on the anniversary of the accreditation (panel hearing) date and contains the following information:

Current standards compliance levels – This includes any changes in standards compliance since accreditation, listing on a standard-by-standard basis any standard with which the agency has fallen out of compliance or achieved compliance.

Update of plans of action – A progress report is included with respect to plans of action submitted to the hearing panel, indicating completion of plans resulting in compliance with standards and revised plans reflecting the need for additional time, funds, and/or resources to achieve compliance.

Significant Events- A report is made of events and occurrences at the agency during the preceding year that impact on standards compliance, agency operation, or the quality of services provided by the agency. This might include:

- A change in the agency administration and/or major staffing changes mission change or program revisions.
- Mission change or program revisions.
- Changes in the offender population, including number of offenders or general offender profile.
- Physical plant renovations, additions, or closing.
- Any major disturbances, such as extended periods or lock-down, employee work stoppages, etc.
- Any significant incident to include allegations of physical/sexual abuse.
- A death from other than natural causes.

Standards and Accreditation Department staff review the annual report received from the agency and respond to clarity issues or request additional information if necessary.

In addition to submission of the annual report, the agency is responsible for notifying Standards and Accreditation Department staff of any major incident, event, or circumstances

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that might affect standards compliance. This notice must be provided to the Standards and Accreditation Department immediately following the event. For example, an agency must notify the Standards and Accreditation Department if it is the subject of a court order, has a major disturbance, escape, physical/sexual abuse (to include allegations), employee work stoppage, death from unnatural causes, or experiences a major fire or other disaster. It it the responsibility of the accredited agency to inform Standards and Accreditation Department staff or provide them with copies of news articles, special reports, or results of investigations that address conditions that affect standards compliance.

Finally, the Standards and Accreditation Department may request that the agency respond to public criticism, notoriety, or patterns of complaint about agency activity that suggests failure to maintain standards compliance. The Standards and Accreditation Department may conduct an on-site monitoring visit to the agency to verify continued compliance.

Monitoring Visits

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) in order to assess continuing compliance with the standards. A monitoring visit may be conducted at anytime during the accreditation period, with advance notice to the agency. The determination of need for a monitoring visit is based on:

- Compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing.
- Incidents or events reported by the agency in its annual report.
- Problems indicated by adverse media reports or correspondence received by Standards and Accreditation Department staff, disturbances at the agency, or special investigations.

The length of the visit varies depending on the number of standards or special issues that must be addressed during the visit. The visits are conducted similar to standards compliance audits, but on a reduced scale. Monitoring visits are charged to the agency at a rate of cost plus twenty-five percent.

Activities, as a general rule, involve a review of all mandatory standards, all standards found in non-compliance at the time of accreditation, and any other concerns identified by the Commission. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit. The report includes a list of standards reviewed, explanation of non-compliance findings, results of the tour and interviews with agency staff and offenders, and discussion of any issues believed to be relevant to the agency's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the agency by Standards and Accreditation staff.

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When a monitoring visit to the agency reveals deficiencies in maintaining compliance levels that existed at the time of accreditation, or less than 100 percent compliance with mandatory standards, the agency prepares a response providing explanation of the problems indicated in the report. When the agency has failed to maintain compliance with all mandatory standards, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections for review during a regular hearing. Agency representatives are advised of the date, time, and location of the review, and are invited to attend. At the discretion of the Commission, the agency may be placed in probationary status and a revisit conducted to determine if deficiencies have been corrected.

Revocation of Accreditation

If the Commission panel believes that an agency's failure to maintain continuous compliance with certain standards is detrimental to life, health, and safety of residents and staff, the Commission may place an agency on probation. Probationary status last for a specific period of time designated by the Commission at its next regularly schedule meeting. The Commission again reviews the program and considers removing the probationary status or revoking accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted, the agency resumes its status as an accredited agency. An agency that does not satisfactorily correct the deficiencies may be withdrawn from accreditation.

Another condition that may result in a rehearing and consideration of revocation is following a significant event in an agency (i.e. major disturbance, death from other than natural causes or allegations of physical/sexual abuse of offenders). Failure to notify the Standards and Accreditation Department in a timely manner may result in suspension of the agency's accreditation. Once ACA is notified of the major event, the Director of Standards and Accreditation may consult with the Executive Committee of the Commission, who may request a monitoring visit. If a visit is warranted, ACA will notify the agency and a date will be established with the concurrence of the facility. The monitoring visit will take place within14 days of this notification. The monitoring visit report will be sent to the Director of Standards within 7 days of the monitoring visit and then forwarded to the Executive Committee of the Commission. Following review of the report, a determination will be made by the Executive Committee as to whether revocation of accreditation is warranted. Prior to any rehearing, agency representatives will be notified, so that any issues may be addressed and responded to in writing.

Accreditation is revoked for the following reasons:

- Failure on the part of the agency to adhere to the provisions on the contract.
- Failure on the part of the agency to maintain continuous compliance with the standards at levels sufficient for accreditation.
- Intentional misrepresentation of facts, lack of good faith, or lack of deliberate speed or a concerted effort to progress in the accreditation process, including the implementation of plans of action.

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- Failure to notify ACA of significant incidents in the annual report to the Commission.

- Adverse conditions of confinement that affect the life health, and/or safety of staff and offenders.

- Failure to comply with the conditions of probation or suspension.

Standards and Accreditation Department staff notify the agency in writing of the specific reasons identified by the Commission for the revocation hearing. Agencies may appeal the decision of the Executive Committee to the full board of the Commission on Accreditation for Corrections. Appeals must be submitted within 30 days. The agency may apply to re-enter the process 180 days after the revocation of accreditation.

Expiration of Accredited Status

Accreditation is granted for a three year period. Unless the agency has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the agency from Accreditation Status after this three year period.

For agencies in Accredited Status that are seeking subsequent accreditation, administrative extensions of Accredited Status may be granted under certain conditions. For example, relocation of the facility, staff turnover, and major renovations often warrant an extension. In these cases, a written request to the Director of Standards and Accreditation is required, outlining the reasons for extending the accreditation period. Agencies that fail to successfully complete an audit within the three year period, or do not receive an extension prior to their expiration date, are withdrawn from Accredited Status.

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Visiting Committee Report and Hearing Minutes

CONFIDENTIALITY

The American Correctional Association and the Commission on Accreditation for Corrections do not disclose to external parties specific information contained in this Accreditation Report or information discussed in the Accreditation Hearing. The Association encourages all participating agencies to provide information to the media about their accreditation activities, including disclosure of the Self-Evaluation and Accreditation Report.

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE INITIAL AUDIT

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

June 5 - 6, 2017

VISITING COMMITTEE MEMBERS

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ACA Auditor
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Atlanta, Georgia 30321
(404) 775-(b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

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A. Introduction

The audit of the Port Isabel Service Processing Center (IHSC), Los Fresnos, Texas was conducted on June 5-6, 2017 utilizing the American Correctional Association (ACA) Standards for Performance Based, Health Care for Adult Correctional Institution, 1st Edition and the 2014 Standards Supplement. The following team conducted the audit:

(b)(6); (b)(7)(C)

B. Facility Demographics

Rated Capacity: 960 (Males - 840 and Females - 120)
Actual Population: 879 (Males - 806 and Females - 73)
Average Daily Population for the last 12 months: 1049
Average Length of Stay: 8 days

(b)(7)(E)

Age Range of Detainees: 18-74
Gender: Male/Female

(b)(7)(E)

C. Facility Description

The Port Isabel Service Processing Center (IHSC), also known as Port Isabel Detention Center (PIDC), Los Fresnos, Texas is located in the southernmost part of the state of Texas along Rural Route 510 in the eastern portion of Cameron County, approximately 20 miles north of Brownsville, Texas and 30 miles east of Harlingen, Texas. The U.S./Mexico border is approximately 22 miles south of PIDC. The Cameron County Airport to the north, the Laguna Atascosa National Wildlife Refuge to the east, agricultural fields and shrimp farms to the south, and agricultural fields to the west surrounds PIDC. PIDC is the largest ICE detention center in the US.

PIDC is a 350-acre facility; 262 acres of developed land and 88 acres of undeveloped native grounds that serve as a habitat for local wildlife, to include the endangered Ocelot species.

PIDC has a new administration building (administration, deportation, five executive offices for Immigration Review (EOIR) courtrooms, training area, muster room, computer lab, and Intel office), male processing area, and a health care facility with 36 short-stay beds, eight negative pressure rooms, and six mental health rooms).

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The Rio Grande Valley (RGV) Staging area (part of the RGV Operations) is the hub for the organization and distribution of the newly detained immigration violators. In 2007, a new 750,000 gallon water tower was completed and new water lines were installed. There are four housing units; A (Alpha Unit), B (Bravo Unit), C (Charlie Unit), and D (Delta Unit).

Formerly, the site was a military installation used by the Army Corps in the 1940s as a gunnery training facility. Then, the Navy and Air Force used the facility, which included an auxiliary airfield for defense and training activities in the 1050s and early 1960s prior to its closure. With realignment and closure of the military facilities in 1962, portions of the property were turned over to the former U.S. Immigration and Naturalization Service (INS) between 1961 and 1963. Other portions of the property, to include the hanger and airfield, were turned over to Cameron County Commissioners for the Port Isabel Airport in 1963.

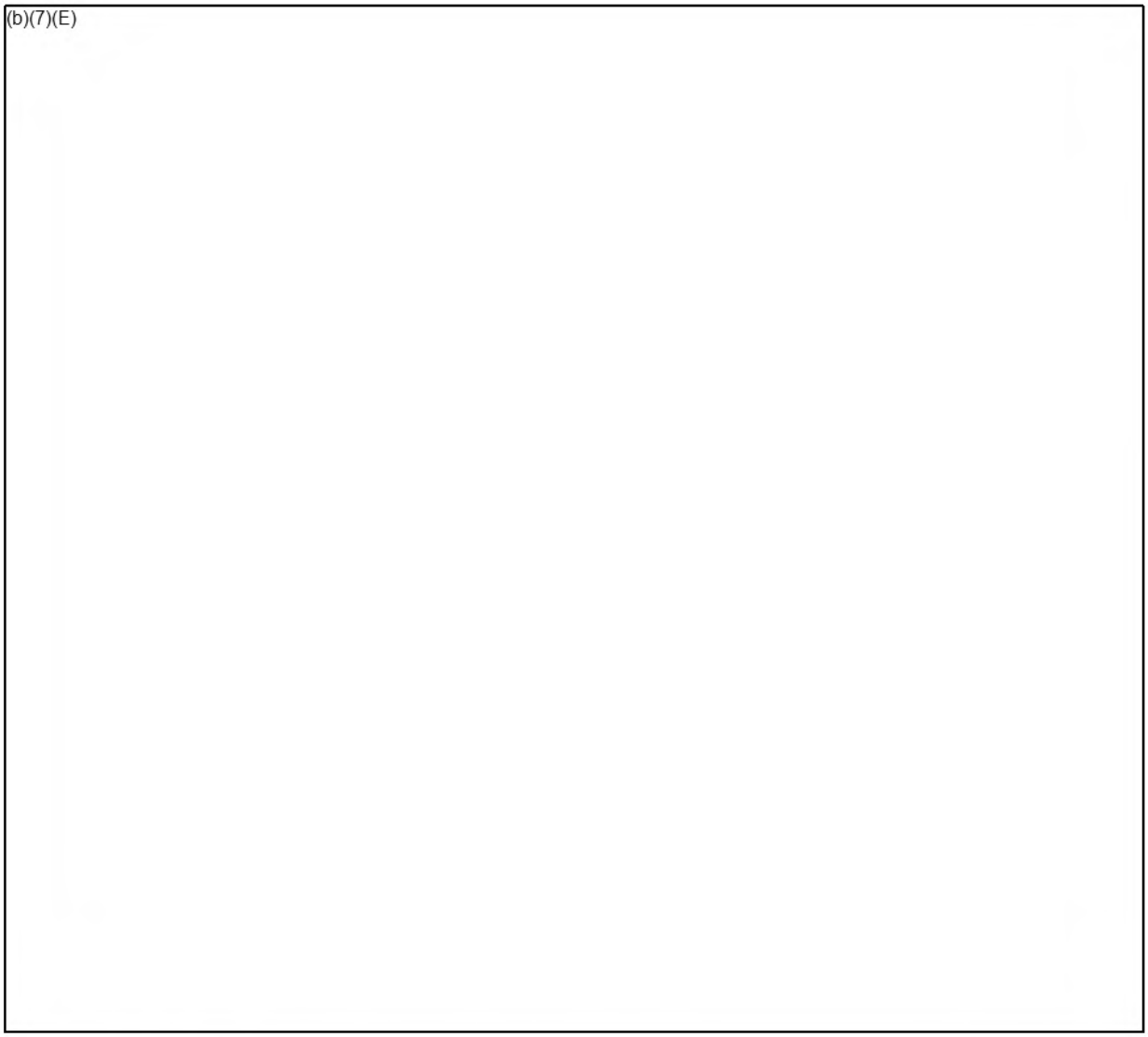
From 1962 to 1963, INS performed major renovations to several buildings on the facility and established a Border Patrol Training Facility and Detention Center. In 1977, the Training Academy expanded and was relocated to the Federal Law Enforcement Training Center in Glynco, Georgia, but the detention center remained. The center is a self-supported facility that continues to house individuals detained for alleged violations of the immigration laws of the United States. These individuals comprising of males and females are detained to ensure they appear before an administrative immigration judge with EOIR. PIDC does not provide housing for individuals awaiting formal criminal charges with outside law enforcement agencies, but it does have a high security level for detainees with a previous history that are classified as close custody. All detainees at the center are solely for administrative charges. In 2006, the facility experienced and expansion with a new administration and medical building which also encompasses processing and visitation.

The demographics of the PIDC detainees currently reflected a population consisting of approximately 97% non-criminal and 3% criminal detainees (FY 2016). The facility has 14-bed Special management Unit (SMU) to assist with disciplinary and administrative cases. The previous medical department building was converted into a "Detainee Services" building consisting of a commissary, barber shop, multipurpose/chapel area, law library and leisure library. An expanse of unutilized land was converted into a large outdoor recreation areas complete with almost full size soccer field as well as a second smaller soccer field.

ICE Health Services Corps Mission Statement -"IHSC is committed to providing health care services to reduce global disease and support the safe apprehension, enforcement and removal of detained individuals involved in immigration proceedings".

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(b)(7)(E)



D. Pre-Audit Meeting

On Sunday, June 04, 2017 the members of the audit team were transported from the Harlingen Airport, Harlingen, Texas to the (b)(7)(E) Deportation Officer (b)(6); (b)(7)(C) with one of the Team Members arriving early at 10:15 a.m. and the Chairperson arriving later at 09:15 p.m. due to flight delay. Transportation includes simultaneous ACI team members. The distance from the airport to the hotel was approximately 1.9 miles.

The audit team met at the hotel on that evening to discuss the information provided by the Association staff and the officials from the Port Isabel Service Processing Center (IHSC). The chairperson divided the standards into the following groups:

Standards #HC 1A-01 to 3A-11 to (b)(6); (b)(7)(C)
Standards #HC 3A-12 to 7C-01 to

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The audit team member attended an "ice-breaker" dinner at the Texas Roadhouse restaurant approximately from 05:30 p.m. to 07:50 p.m. that evening with Lieutenant (b)(6); (b)(7)(C) Assistant Health Services Administrator-Public Health Services (PHS), (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) General conversation followed as the team member and the IHSC staff became acquainted, and general audit goals and procedures for the audit were discussed. The audit chairperson was not present at the dinner due to a flight delay.

E. The Audit Process

1. Transportation

On Monday, June 05, 2017, the audit team was picked up from the hotel by (b)(6); (b)(7)(C) the Deportation Officer at 07:34 a.m. and arriving PIDC at 8:16 a.m. The team followed the PIDC's security procedures and was escorted to the main executive conference room by (b)(6); (b)(7)(C) the Assistant Field Office Director (b)(6); (b)(7)(C) the Assistant Health Services Administrator and (b)(6); (b)(7)(C) the Nurse Manager for a brief meeting from 08:18 a.m. to 08:25 a.m.

2. Entrance Interview

At 8:26 a.m. the audit team proceeded with the formal entrance meeting at the same conference room with IHSC and the PIDC executive team for a joint (IHSC/ACI) entrance audit meeting. The audit schedule and procedures were discussed, and the IHSC staffs were asked about any problem areas of which the team should be aware. The IHSC executive staffs were advised that the audit team would meet with them each evening prior to their departure from the facility to discuss the progress of the audit up to that point, and any problems that were encountered, and the audit team will attempt to review all the mandatory standards on the first day. Escorts were requested to accompany the auditors on the tour and subsequent visits to departments, and to note the number of detainees and the names and titles of employees with whom the auditors spoke. The IHSC staffs were asked if any detainee or employee had requested to speak with the auditors. No requests had been made. The audit Chairman expressed the team's appreciation and the appreciation of the ACA for the opportunity to be involved with the IHSC audit in its initial accreditation process, and emphasized the goals of the accreditation, which are to improve the efficiency and effectiveness of correctional systems throughout the United States. The audit team was aware that the facility staff, especially the IHSC staff had worked long and hard in preparation for this event, and accordingly the team would endeavor to provide a fair, equitable and thorough audit as possible while holding them accountable to high standards. The team members would visit as many departments and areas as possible relating to the audit and meet and speak with as many staff and detainees as possible in the time available, while at the same time strive to be as non-intrusive as possible.

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It was requested that when audit team members paused to speak with detainees, that staffs step away so that the conversation may remain private and the team would like to observe the practice in any medical emergency. The audit team reemphasized that the purpose of the audit is to be helpful and to assist the facility in achieving its initial accreditation. Again the audit process and schedule were discussed. The entrance meeting lasted until 08:45 a.m. The following persons were in attendance:

PIDC/IHSC Staff

(b)(6); (b)(7)(C)	Quality Control Safety Compliance Officer Supervisor Detention and Deportation Officer Assistant Field Officer Director Assistant Health Services Administrator Compliance Officer Nurse Manager Chief of Security Project Manager Assistant Project Manager Food Service Manager Supervisory Detention and Deportation Office Deportation Officer Contracting Officer Representative Fleet Supervisor Detention Standards Compliance Officer Quality Control Officer Building Manager Compliance Officer (ICE) Compliance Officer (ICE) ACA-ACI Audit Chairperson ACA-ACI Audit Team Member

3. Facility Tour

The team toured the medical area and other areas relating to the IHSC audit from 08:50 a.m. to 10:51 a.m. ACA audit notices were posted throughout the facility. Staff and detainees were aware that an audit was taking place. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

(b)(6); (b)(7)(C)	Quality Control Safety Compliance Officer Supervisor Detention and Deportation Officer Assistant Field Officer Director Assistant Health Services Administrator Compliance Officer Nurse Manager

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(b)(6); (b)(7)(C)	Chief of Security Project Manager Assistant Project Manager Food Service Manager Supervisory Detention and Deportation Office Deportation Officer Contracting Officer Representative Fleet Supervisor Detention Standards Compliance Officer Quality Control Officer Building Manager Compliance Officer (ICE) Compliance Officer (ICE)

The following areas of the institution were visited and the following personnel and detainees were encountered during the course of the tour:

Staging	(b)(6); (b)(7)(C)
Processing Site	
Property	
Medical	
Infirmary	
Food Service	
Special Management Unit	
Laundry	
Pharmacy	

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4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Food Service:

Foodservices are contracted through the Ahtna Support and Training Services, LLC, (AhtnaSTS), a Support Services and Management company. All meals provided are approved by a certified dietician and are nutritionally balanced, and are properly prepared. Meals are served in clean and safe surroundings. There is no pork products served in this facility. Medical diets are provided by the Food Service Department upon receipt of written instructions from the facility Clinical Director. Meals are served in the day room of each housing units. Detainees in the Special Management Unit (SMU), Infirmary, etc. are served in their cells. The facility utilizes a five week menu cycle, and based on two hot/one cold meals per day and 3,000 calories per day (98 grams of protein, 30% fat and 4,310 mg of Sodium). There were recommended efforts to reduce Sodium level. Meals samples are kept for 72 hours. At the time of the audit, there were 74 medical diets. These diet orders contain both start and stop dates. These may be ordered anywhere from one day to length of stay. Diabetics on insulin have midnight snacks. Medical evaluations and screenings are done on detainee workers which monitored cuts/sores, burns, runny nose; nail condition and cold/flu symptoms. Detainees are not allowed to handle food preparation. Refrigerators, freezers and the dry storage area were clean, orderly and clutter-free, and temperatures were in the appropriate ranges. The dishwasher was in proper working order, and documentation reflected temperatures in the appropriate range.

Medical Care:

Medical services at the Port Isabel Detention Center (PIDC) are contracted through the INGENESIS. They also utilize Public Health Service (PHS) and Government Service (GS) staffing. They provide medical, mental health and dental services. PIDC medical receives detainees throughout the U.S and some with the history of high-risk behaviors, compounded by lack of medical care and /or mental health treatment, and are more likely to have chronic illnesses and infectious diseases. The facility has a responsible physician (MD) and a Health Services Administrator (HSA). The working relationship between medical, mental health, program, dental and security are very remarkable. Medical staffs are well trained and caring professionals. Between June 2016 - July 2017, IHSC-PIDC provided intakes - 27,997, sick call - 11,358, procedures simple-4,825, vital signs-1,014, physical examination (simple) - 6,012, mental health appointments - 6,460 and prescriptions - 31,810.

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Other accreditation for the PIDC includes National Commission on Correctional Health Care (NCCHC) and Performance Based National Detention Standards 2011 (ICE). All detainees receive initial screening up arrival, and physical exam within 14 days of arrival.

(b)(7)(E)

(b)(7)(E) The audit team observed shift changes on first and second day of the audit and found the process structured. The PIDC medical has twelve examination rooms (including the medical trailer) plus one urgent care room (two exam tables). The waiting rooms have access to water, bathrooms, education materials and health pamphlets. Telemedicine is not available at the PIDC. New fulltime employees receive in-service trainings and OJT trainings.

PIDC medical has the followings:

- 3 AED's (secured and inspected)
- 2 EKG's (secured and inspected, and read on site)
- 1 Fixed wall stand digital x-ray machine
- 2 Emergency bags (secured, inspected and sealed)
- 2 Emergency stretchers with straps (secured and inspected)
- 2 Transport Gurneys (secured and inspected)
- 5 Secure administration medication rooms
- 2 Medication rooms
- 2 Pill windows
- 4 Refrigerators (Flu, TB Solutions, etc.)
- 3 Refrigerators (Specimen)
- 7 Portable oxygen cylinders (secured and inspected by Matheson Gas)
- 8 Negative pressure room (camera, toilet and sink, and inspected)
- 8 -21bed infirmary room (shower chair, shower grab bars, camera, toilet, sink and handicap accessible)
- 1 Suicide observation room (padded, camera, toilet and sink)
- 5 Single bed Isolation rooms (cameras and intercom systems)

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- 2 Medical emergency yard-vehicles

PIDC has a Disability Placement Program (DPP) that provides for housing accessible lockers, bunk beds with grabs bars, accessible TTY phones, volume control phones, accessible dayroom tables and accessible path of travel.

There are ample supplies of walking sticks, crutches and wheel chairs in the facility. Physical Therapy is provided through the VBMC Round Outpatient Rehabilitation, Harlingen, TX.

PIDC uses the following hospitals for inpatient hospitalization:

1. Valley Baptist Medical Center, Harlingen, TX (local ER, Surgery, Dialysis)
2. Harlingen Medical Center, Harlingen, TX (Radiology)
3. Valley Baptist Medical Center, Brownsville, TX
4. Valley Regional Medical Center, Brownsville, TX

PIDC has an agreement with the Los Fresnos Fire Department and EMS, and Port Isabel EMS (30-45 minutes) in case of medical emergencies. Non-emergent medical transportation is done by facility staff to either a hospital facility or community provider for offsite consultations. The nurses have Basic Life Support (BLS) certified through the American Heart Association (AHA). Medical maintain basic TTA protocol medicine such as Epinephrine, Narcan, Glucagon and etc. The Master SDS is maintained in medical. Officers are trained on first aid, CPR and AED, and are considered first responders. Upon admittance to the PIDC, detainees receive a detainee handbook to aid in adjustment to detention setting. This documentation contains information regarding medical services, sick call process, grievance procedures and hygiene rules. Other methods are used to inform detainees about MRSA, AIDS, Hepatitis, and the spread of HIV, blood borne pathogens and safety. PIDC has two dedicated medical emergency yard-response vehicles. There is a provision for helicopter landing, and service provided by the Valley Air Care, Harlingen, TX

Sick call is provided seven days/week in General Population (GP) and Special Management Unit (SMU) from 07:00 a.m. – 10:00 a.m. daily for females and all day for the males. Detainees sign up for .sick calls at each housing unit between the hours of 05:00 a.m. and 06: 00 a.m. the SMU has seven cells (14 beds). Detainees housed in SMU access all medical services via face to face encounters with an RN during daily rounds. Detainees housed in GP access all medical services via call out logs. The average monthly sick calls are 728. The audit team observed sick call process in GP and SMU on the second day of the audit and found the process well organized. Medical requests are triaged within five days, and any patient with symptoms is seen within one day. There is no medical copay.

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No detainee is denied health care service. PIDC uses detainee electronic medical records. Medical grievance is through the grievance box, collected by a grievance coordinator, and reviewed by the HSA within seven days.
PIDC averages five substantiated medical grievances per year mostly on medication preference, medication refills and time line to see a provider.

Services such as Physical Therapy, General Surgery, Cardiology, Dermatology, Endocrinology, Endodontist, Gastroenterology, Hematology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Orthopedic, OBGYN, Ophthalmology, Oncology, ENT, Podiatry, Pain Management, Urology, Pulmonary, Neuro Surgery, Plastic Surgery, Oral Surgery, Rheumatology, Optometry, Asthma and Allergy, Sleep Study are provided through off-site contracted specialists. The turnaround time to see an offsite contracted specialist is emergent-immediate, urgent one-day and routine 14-days. There were no pregnant detainees or detainees on dialysis at the time of the audit. The number of chronic care detainees excluding mental health at the time of the audit was113.

PIDC has a plan for the management of communicable diseases including education on prevention, diagnosis, treatment and isolation. PIDC has an infectious disease coordinator. PIDC has eight single bed negative pressure rooms and eight rooms (21 beds) infirmary rooms. The Infirmary rooms are ADA compliant. The negative pressure rooms were serviced by the Air Management Solutions, Powder Springs, GA on 01/01/2017 with air exchanges per hours (ACH) averaging 12 per room. Some of the negative pressure and infirmary rooms were occupied at the time of the audit. MRSA precautions are in place. Universal precautions are practiced throughout the facility. There are available first aid and blood borne pathogen kits. There are eye wash stations present in appropriate areas. Hand sanitizers (non-alcohol) dispensers were located throughout medical and other areas. Sanitation and housekeeping is provided using detainee help. The total monthly TB tests are 18. An annual TB testing is conducted on all detainees after 12 months. PIDC does not offer TB sticks only chest x-rays.

Medications are stored in medication rooms and secured behind double locks. A nurse administers medications two times a day and seven days a week in GP and SMU by direct observed therapy (DOT) from 07:30 a.m. – 08:00 a.m. and 07:30 p.m. – 08:00 p.m. Prior to giving medications, detainee's identification is confirmed and mouth cavities checked after administration. The audit team observed medication administrations in the GP and SMU, including diabetic line on the second day of the audit and found the process organized and timely. All no shows or refusal to medications are documented and /or referred. The HSA checks the MARS record for missed doses. Keep on person medications are issued on 1:1 exchange. . – 06:00 a.m. and 03:15 p.m. – 03:30 p.m. At the time of the audit there were eight diabetics (five insulin and three non-insulin dependents). Insulin diabetic detainees receive mid-night snacks. The detainees are trained to self-administer selected medications.

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Medical diets are coordinated with the food service. The audit team examined the manual during the audit and found it current. The manual is updated regularly by medical. There were 74 medical diets at the time of the audit. The average monthly detainees on prescription medications were 474, and controlled medications were 19. Some medications are crushed per doctor's order. Detainees are provided 30-day medications upon release, and ten days for diabetics. Specific Over-The-Counter (OTC) medications are offered at the Commissary, and reviewed and approved by the Clinical Director.

PIDC has a licensed pharmacy, and supported by the following fulltime staffs: one Pharmacist (GS), and two Pharmacy Technicians (Contract). PIDC maintain stock order medications. Medications are ordered through Diamond and McKesson Pharmacy with next day delivery of 5:00 p.m. order for Diamond and 7:00 p.m. order for McKesson. The backup pharmacy is the local CVS Pharmacy. Detainees are allowed keep-on-person (KOP) medications. The pharmacy is audited by the Pharmacist monthly and the HSA quarterly. A random inventory count on sharps and controlled medications was accurate. The pharmacy has a refrigerator and a freezer for the storage of insulin, vaccines and ice packs. The audit team found the temperature log and inventory current. Facility has ample supplies for universal precautions. Basic medical supplies and materials are obtained through McKesson. The disposal of expired, unused, discontinued, recalled, over stocked medications including prescription, (pills and liquids) and narcotics are arranged through the Diamond Pharmacy and Guarantee Returns. At the time of the audit there were some medications awaiting disposal. Records are maintained on disposal process.

PIDC medical has a draw only lab. Specimens are collected on site. Blood is spun and sent out for analysis to the LabCorp five–days/week and reports received through fax/phone within 24-48 hours. STAT labs are also sent to the Valley Baptist Medical Center, Harlingen, TX and results received through fax/phone within 2-4 hours. Average monthly detainee lab tests are 345. Stericycle is contracted to pick up the biohazard and sharps wastes. The audit team checked the specimen refrigerator temperature log and found the records current. Chronic care patients receive annual screening test. Laboratory results are also incorporated into the EMR. Digital radiology is used in the facility with hard copy over-reads scanned into the electronic health record (EMR). PIDC has a fixed wall stand digital x-ray machine. The X-ray department is supported by three fulltime contracted Radiology Technicians. Radiology services (MRI, Ultrasound, etc.) are provided through Mobile Imaging of Rio, Grande Valley, TX, and STAT radiology provided at the Valley Baptist Medical Center, Harlingen, TX with results received in two hours by phone/fax.

PIDC performs detoxification from alcohol, opiates hypnotics, other stimulants and sedative hypnotic drugs. Substance abuse treatment is provided, as are a large number of behavioral health groups and classes. All detainees enrolled and participating in these groups had individual treatment plans in place.

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There are regularly scheduled Multi-Disciplinary Team meetings, including medication management when appropriate and necessary.

One F/T Dentist (PHS) and one F/T Dental Assistant (Contract) support PIDC dental. Dental services are provided from 07:00 a.m. - 03:30 p.m. (Monday-Friday). Dental services include basic dentistry, prophylaxis, fillings, partials, extractions, cleaning, oral cancer screenings and patient education. The detainees access dental health services through the sick call process. The audit team reviewed the licenses, registrations, records and random inventory of sharps and instruments and found them accurate. The dental area was clean. Dental instruments and sharps not used at the year of expiration are re-autoclaved and repackaged. Dental sterilization test is through MaxiTest and Crosstex Biological Monitoring Services. The Dentist has a standing order; dental emergency outside the expertise of the nurse is referred to one of the contracted hospitals. The Dentist is notified. Dental at PIDC is equipped with two digital dental bitewing x-ray machines, three dental chairs and one Panorex digital x-ray machine. The dental wait time is less than seven days. Urgent requests are seen within 24 hrs. The average monthly dental appointment is 51. Dental amalgam disposal is through CapSecure. Dosimeter reading is through PRS Dosimetry. Dental chair traps are cleaned weekly. Dental supplies and equipment service, including dental compressor service are obtained through the Henry Schein. Broken tools are documented and disposed by facility maintenance.

PIDC mental health is supported by one F/T Psychiatrist (Contract), one F/T Licensed Clinical Social Worker (PHS) and two F/T Licensed Clinical Social Workers (Contract). They provide services 24/7. Daily rounds are conducted. Detainees access mental health services via the sick call process. Staffs can refer services. There are approximately 383 detainees seen monthly. All suicide ideations are referred to Mental Health and monitored, and observed 1:1. Mental Health utilizes the six single-bed isolation rooms, including a padded cell. There are available suicide smocks and blankets. Tele-psychiatry is practiced at PIDC. PIDC maintains zero tolerance for sexual abuse and harassment. Detainees are provided information on enhanced victim services and rape crisis hotline. Detainees are provided mental health appraisals 14 days of arrival and are evaluated every 30/60/90 days depending on needs. Program services include crisis intervention, individual and group counseling and medication management. PIDC has no therapeutic community program. Severely developmentally and disabled detainees receive a mental health evaluation where appropriate and are referred for placement at the following inpatient hospitals:

1. Columbia Regional Care Center, Columbia, South Carolina
2. Nix Behavioral Center, San Antonio, Texas
3. South Texas Behavioral Center, Edinburg, Texas

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There were approximately 109 detainees on psychotropic medication at the time of the audit. PIDC conducts peer review evaluations. PIDC has six suicide observation rooms. In addition, four of the negative pressure rooms are dedicated to mental health. There are available suicide garments.

Laundry:

The audit team observed adequate supply of bed linens, pillows and blankets. Laundry process is done using mess bags. Bed linens, pillow cases and blankets are exchanged weekly and clothing are exchanged two times per week. Medical has adequate supplies of linens and clothing to support infirmary and medical housing. Medical wastes are contained and washed separately using biohazard dissolving bags.

F. Examination of Records

Following the facility tour, the team proceeded to the medical conference room to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

The facility had no consent decrees, class action lawsuits or adverse judgments in the past year.

2. Significant Incidents/Health Care Outcome Measures

Significant Incident Summary:

The following significant incidents occurred during the period May 2016 through April 2017.

A report of significant incidents which occurred during the accreditation period is presented below:

Escapes:	0
Disturbances:	0
Sexual Violence:	0
Homicide:	0
Assault, Detainee-on-Detainee:	12
Assault, Detainee-on-Staff:	5
Suicide:	0
Non-Compliance with a Mandatory Standard:	0
Fire:	1
Natural Disaster:	0
Unnatural Death:	0

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DHS-ICE-20-0618-A-001107

Other: 0

The number of detainee-on-detainee assaults was 12, Detainee-on-Staff assault was five and the number of fires was 1for an average detainee daily population of 1049 for the audit period.
While some of the numbers are significant and will impact health care services, however, it was determined that the number and types of incidents reflected for the past 12 months as described above were within the appropriate range that would be expected for an institution of this size, custody level and mission.

Health Care Outcome Measures:

The audit team reviewed the health care outcome measures with the health care administrative team. During the audit period there were no deaths. There was no evidence of open medical lawsuits. There was discussion regarding the following sections on the healthcare outcomes during the audit period:

1. Section 1A (3)-Number of detainees who are new converters on a TB test that indicates newly acquired TB infection during the audit period was 73, and the number of detainees administered tests for TB infection during the audit period as part of periodic or clinically-based testing, but not intake screening was 124. PIDC provided statement that the facility is an immigration processing center and houses diverse detainee population, and some have not seen a doctor before.
2. Section 1A (13)-Number of selected hypertensive offenders at a given point in time with a B/P reading >140 mmHg/>90mmHg was 21, and the total number of detainees with hypertension who were reviewed were 25. The PIDC provided statement that there were recommended efforts to reduce sodium level in diet and improve detainee physical wellness education. The PIDC is an immigration processing center. Some of the symptoms are pre-existing.
3. Section 1A (14)-Number of selected diabetic detainees at a given point in time who are under treatment for at least six months with a hemoglobin AIC level measuring greater than 9 percent was 23, and the total number of diabetic detainees who were reviewed was 30. PIDC provided statement that the facility is an immigration processing center and houses diverse detainee population, and some have not seen a doctor before.
4. Section 1A (15)-The number of completed dental treatment plans within the past twelve (12) months was 18, and with average daily population during the reporting period of 1057. PIDC provided statement that the average length of stay of detainees is 8 days.
5. Section 4A (6)-Number of serious medication errors in the past twelve (12) months was 8. PIDC provided statement that there were no serious medical intervention or employee discipline. Additional training was provided to employees.

AMERICAN OVERSIGHT

The values stated for the measures reflected a very busy facility with high transfer detainees from diverse population and age, with a wide variety of health concerns. The medical auditor concurs with the responses.

3. Departmental Visits

The team revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Intake Staging	(b)(6); (b)(7)(C)
Medical Trailer	
Medical	
Medical Infirmary	
Food Service	
Special Management Unit	
Property	

4. Shifts

a. Day and Evening Shifts

The team was present at the facility during the day and evening shifts from 08:16 a.m. to 05:40 p.m. on the first day of the audit. The team observed evening shift briefing at 03:00 p.m. comprising of medical, mental health, dental and security. The briefing was mutual and participatory. The team briefly introduced themselves and discussed the purpose of the audit and matters pertaining to the audit.

AMERICAN OVERSIGHT

The team observed diabetic line while the rest of the medical staff was busy taking care of the detainees and are pleasant and professional.

b. Night Shift

The team was present at the facility during the night shift at 07:00 a.m. on the second of the audit. The audit team observed the shift change and morning briefing. As usual, the briefing comprises of medical, mental health, dental and security. Shift briefings are a normal occurrence. The shift supervisors passed on information to the oncoming shift. A familiar and easy rapport was evident among the staff, and information was freely exchanged.

5. Status of Previously Non-compliant Standards/Plans of Action

There were no standards previously found non-compliant. This is an initial accreditation audit.

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

There were no standards previously found non-compliant or granted a waiver as this is an initial accreditation audit.

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

The audit team interviewed and spoke to approximately 87 detainees, including the oldest and youngest of the males and females who stated that they generally felt secure at the facility and were treated fairly by staff. Their basic needs were being met and they felt that they were making positive progress towards eventual and successful release. They also felt that their basic medical needs were being met. They have ready access to sick call process and all were aware of the grievance process. Detainee morale appeared to be good and they were cooperative, respectful and were aware of the audit, and participated in the preparation for the audit. Notices of the ACA Accreditation process were observed to have been posted at different locations readily available to the detainees, and there were no detainees requested to speak privately with the audit team.

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2. Staff Interviews

The audit team interviewed and spoke to approximately 45 employees, including 21 medical staffs, and observed them in the performance of their duties.

The audit team observed structured medical shift change briefings. Staffs were polite, cooperative, and conducted themselves in a professional manner. There was a normal working relationship between medical, dental, mental health, programs and security, and communication flowed freely. Gender and ethnic diversity was good and morale also appeared to be good. Staff indicated that their training were excellent and are applicable to their positions and job needs.

H. Exit Discussion

The exit interview was held at 11:16 a.m. in the medical conference room with the Health Services Administrator, one ICE Deportation Officer, one Compliance Office and four Health Care staffs.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive to maintain their high level of professionalism in the correctional field.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Performance Based Health Care for Adult Correctional Institution, 1st Edition	
Supplement	2014 Standards Supplement	
Facility/Program	Port Isabel Processing Center (IHSC)	
Audit Dates	June 5 - 6, 2017	
Auditor(s)	(b)(6); (b)(7)(C) -Audit Chairperson Audit Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	44	91
Number Not Applicable	1	5
Number Applicable	43	86
Number Non-Compliance	0	0
Number in Compliance	43	86
Percentage (%) of Compliance	100	100

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

AMERICAN OVERSIGHT

COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

June 5 - 6, 2017

Visiting Committee Findings

Mandatory Standards

Not Applicable

Standard #1-HC-3A-09

THE USE OF OFFENDERS FOR MEDICAL, PHARMACEUTICAL, OR COSMETIC EXPERIMENTS IS PROHIBITED THIS DOES NOT PRECLUDE INDIVIDUAL TREATMENT OF AN OFFENDER BASED ON HIS OR HER NEED FOR A SPECIFIC MEDICAL PROCEDURE THAT IS NOT GENERALLY AVAILABLE (C) INSTITUTIONS ELECTING TO PERFORM RESEARCH WILL BE IN COMPLIANCE WITH ALL STATE AND FEDERAL GUIDELINES

FINDINGS:

PIDC policy prohibits the use of detainees for medical, pharmaceutical, or cosmetic experiments.

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DHS-ICE-20-0618-A-001113

COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

June 5 - 6, 2017

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #1-HC-1A-02

WHEN MEDICAL COPAYMENT FEES ARE IMPOSED, THE PROGRAM ENSURES THAT, AT A MINIMUM, THE FOLLOWING ARE OBSERVED:

- ALL OFFENDERS ARE ADVISED, IN WRITING, AT THE TIME OF ADMISSION TO THE FACILITY OF THE GUIDELINES OF THE COPAYMENT PROGRAM.
- NEEDED OFFENDER HEALTH CARE IS NOT DENIED DUE TO LACK OF AVAILABLE FUNDS.
- COPAYMENT FEES SHALL BE WAVED WHEN APPOINTMENTS OR SERVICES, INCLUDING FOLLOW-UP APPOINTMENTS, ARE INITIATED BY MEDICAL STAFF.

FINDINGS:

PIDC does not charge detainees copay for any medical services to include pharmaceuticals dispensed by medical personnel.

Standard #1-HC-2A-04

WHEN INSTITUTIONS DO NOT HAVE QUALIFIED HEALTH CARE STAFF, HEALTH TRAINED PERSONNEL COORDINATE THE HEALTH DELIVERY SERVICES IN THE INSTITUTION UNDER THE JOINT SUPERVISION OF THE RESPONSIBLE HEALTH AUTHORITY AND WARDEN OR SUPERINTENDENT

FINDINGS:

PIDC has a qualified health care staff to coordinate the health delivery services.

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Standard #1-HC-2A-16

IF VOLUNTEERS ARE UTILIZED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTION, TRAINING, STAFF SUPERVISON, FACILITY ORIENTATION, AND DEFINITION OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITY VOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAININGC) VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION

FINDINGS:

PIDC does not use volunteers in the delivery of health care.

Standard #1-HC-2A-17

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION, COMMENSURATE WITH THEIR LEVEL OF TRAINING THERE IS A WRITTEN AGREEMENT BETWEEN FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS/INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION

FINDINGS:

PIDC does not use students, interns or detainees in the delivery of health care.

Standard #1-HC-2A-18

UNLESS PROHIBITED BY STATE LAW, OFFENDERS (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE THE FOLLOWING:

(A) PEER SUPPORT AND EDUCATION
(B) HOSPICE ACITIVITIES
(C) ASSISTING IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH ACTVITIES OF DAILY LIVING
(D) SERVING AS A SUICIDE COMPANION OR BUDDY IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF A SUICIDE PREVENTION PLAN

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OFFENDERS ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

(E) PERFORMING DIRECT PATIENT CARE SERVICES
(F) SCHEDULING HEALTH CARE APPOINTMENTS
(G) DETERMING ACCESS OF OTHER OFFENDERS TO HEALTH CARE SERVICES
(H) HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
(I) OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALTY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

PIDC does not use detainees to perform familial duties.

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Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Port Isabel Detention Center Reporting Period: **May**: 2016 – April 2017

Incident Type	Months ⇨	May 2016	June 2016	July 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	0	1	1	4	1	0	1	0	1	2	1	12
	Offender/ Staff	0	0	0	0	0	1	0	1	0	1	1	1	5
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	1	0	0	0	0	0	0	0	1
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*														0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Port Isabel Service Processing Center (IHSC)
MAY 1, 2017 TO APRIL 30, 2017

		Health Care Outcomes		
Standard	**Outcome Measure**	**Numerator/Denominator**	**Value**	**Calculated O.M.**
1A	(1)	Number of offenders diagnosed with a MRSA infection within the past twelve (12) months	3	
	divided by	The average daily population	1057	0.003
	(2)	Number of offenders diagnosed with active tuberculosis in the past twelve (12) months	33	
	divided by	Average daily population	1057	0.031
	(3)	Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months	73	
	divided by	Number of offenders administered tests for TB infection in the past twelve (12) months as part of periodic or clinically-based testing, but not intake screening	124	0.59
	(4)	Number of offenders who completed treatment for latent tuberculosis infection in the past twelve (12) months	73	
	divided by	Number of offenders treated for latent tuberculosis infection in the past twelve (12) months	73	1
	(5)	Number of offenders diagnosed with Hepatitis C viral infection at a given point in time	2	
	divided by	Total offender population at that time.	1057	0.002
	(6)	Number of offenders diagnosed with HIV infection at a given point in time	37	
	divided by	Total offender population at that time	1057	0.035
	(7)	Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time	37	

AMERICAN OVERSIGHT

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	divided by	Total number of offenders diagnosed with HIV infection at that time	37	1
	(8)	Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less than 50 cps/ml	0	
	divided by	Total number of treated offenders with HIV infection that were reviewed.	15	0
	(9)	Number of offenders with an active individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time	25	
	divided by	Total offender population at that time	1057	0.023
	(10)	Number of offender admissions to off-site hospitals in the past twelve (12) months	113	
	divided by	Average daily population	1057	0.11
	(11)	Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months	371	
	divided by	Average daily population in the past twelve (12) months.	1057	0.35
	(12)	Number of offender specialty consults completed during the past twelve (12) months	1320	
	divided by	Number of specialty consults (on-site or off-site) ordered by primary health care practitioners in the past twelve (12) months	1292	1.02
	(13)	Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mmHg/ >90 mm Hg	21	
	divided by	Total number of offenders with hypertension who were reviewed.	25	0.84
	(14)	Number of selected diabetic offenders at a given point in time who are under treatment for at least six months with a hemoglobin A1C level measuring greater than 9 percent	23	
	divided by	Total number of diabetic offenders who were reviewed	30	0.77
	(15)	The number of completed dental treatment plans within the past twelve (12) months	18	
	divided by	The average daily population during the reporting period	1057	0.02

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2A	(1)	Number of health care ***staff*** with lapsed licensure or certification during a twelve (12) month period	0	
	divided by	Number of licensed or certified staff during a twelve (12) month period	68	0
	(2)	Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job	9	
	divided by	Number of new health care staff during the twelve (12) month period.	9	1
	(3)	Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months	0	
	divided by	Number of employees	75	0
	(4)	Number of direct care staff (employees and contractors) with a conversion of a TB test that indicates newly acquired TB infection in the past twelve (12) months	0	
	divided by	Number of direct care staff tested for TB infection in the past twelve (12) months during periodic or clinically indicated evaluations	51	0
3A	(1)	Number of offender grievances related to health care services found in favor of the offender in the past twelve (12) months	5	
	divided by	Number of evaluated offender grievances related to health care services in the past twelve (12) months	21	0.24
	(2)	Number of offender grievances related to safety or sanitation sustained during a twelve (12) month period	1	
	divided by	Number of evaluated offender grievances related to safety or sanitation during a twelve (12) month period	1	1
	(3)	Number of adjudicated offender lawsuits related to the delivery of health care found in favor of the offender in the past twelve (12) months	0	
	divided by	Number of offender adjudicated lawsuits related to healthcare delivery in the past twelve (12) months	0	0
4A	(1)	Number of problems identified by quality assurance program that were corrected during a twelve (12) month period	2	

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	divided by	Number of problems identified by quality assurance program during a twelve (12) month period	2	1
	(2)	Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period	0	
	(3)	Number of offender suicide attempts in the past twelve (12) months	0	
	divided by	Average daily population	1057	0
	(4)	Number of offender suicides in the past twelve (12) months	0	
	divided by	Average daily population	1057	0
	(5)	Number of unexpected natural deaths in the past twelve (12) months	0	
	divided by	Total number of deaths in the same reporting period	0	0
	(6)	Number of serious medication errors in the past twelve (12) months	8	
5A	**None**			
6A	**None**			
7A	**None**			
7B	**None**			
7C	**None**			

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001121

COMMISSION ON ACCREDITATION FOR CORRECTIONS
PANEL ACTION REPORT

America's Center Convention Complex
St. Louis, Missouri

Saturday, August 19, 2017

ICE Health Service Corps
Port Isabel Service Processing Center (IHSC)
Los Fresnos, Texas

Agency Representatives: (b)(6); (b)(7)(C) Assistant Health Service Administrator

Panel Members: (b)(6); (b)(7)(C) Chairperson

Staff: (b)(6); (b)(7)(C)

Panel Action

No actions.

Accreditation Panel Decision

Moved: Commissioner (b)(6); (b)(7)(C)
Seconded: Commissioner

Three-Year Accreditation: Yes

Accreditation Vote	**Yes**	**No**
Commissioner (b)(6); (b)(7)(C)	✓	
Commissioner	✓	
Commissioner	Opted Out due to conflict of interest; he is a IGSA	
Commissioner	✓	
Commissioner	✓	

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Final Tally

Mandatory	100%
Non-Mandatory	100%

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

CoreCivic
Houston Processing Center (CoreCivic)
Houston, Texas

June 10 - 12, 2019

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C) Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

AMERICAN OVERSIGHT

A. Introduction

The audit of the Houston Processing Center (HPC) in Houston, Texas was conducted on June 10-12, 2019, by the following team: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Member.

B. Facility Demographics

Rated Capacity: 1000
Actual Population: 902
Average Daily Population for the last 12 months: 855
Average Length of Stay: 59 days
Security/Custody Level: Medium
Age Range of Offenders: 18-70
Gender: M/F
(b)(7)(E)

C. Facility Description

Mission Statement

We help government better the public good through:

CoreCivic Safety – We operate safe, secure facilities that provide high quality services and effective reentry programs that enhance public safety.

CoreCivic Community – We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society and keep communities safe.

CoreCivic Properties – We offer innovative and flexible real estate solutions that provide value to government and the people they serve.

Houston Processing Center Floor Plan

AMERICAN OVERSIGHT

(b)(7)(E)

AMERICAN OVERSIGHT

The Houston Processing Center began accepting detainees from the Department of Justice Immigration & Naturalization Services (now Department of Homeland Security Immigration & Customs Enforcement/DHS-ICE) in 1984 and housed them at the Olympic Hotel until a detention facility could be constructed.

The facility's first design and construction of the 506 - bed medium security facility was designed and built in six months. The Houston Processing Center began an expansion project in March 2004 that was completed in July 2005 adding approximately 400 beds to the existing facility for a total of 905 beds. In April 2009, 95 additional beds were added bringing the facility bed capacity to 1,000. The facility currently houses criminal and undocumented adult male and female aliens for Immigration and Customs Enforcement (ICE), formerly known as INS.

The Houston Processing Center (HPC) is owned and operated by Core Civic.

The Houston Processing Center is located in the Northeast section of the City of Houston, Texas. Public transportation is available near the facility and numerous freeways and access roads are nearby. The facility enjoys immediate access to the Bush Intercontinental Airport, area hospitals, city, county and state law enforcement agencies, business and industry and all related city services (i.e., transportation, utilities and emergency services).

The majority of detainees being housed at the Houston Processing Center are criminal aliens who are prison-released and have ICE holds (or detainers) and are required to go through administrative immigration hearings before a Federal immigration judge to determine if removal or deportation is in order. In over 90% of the cases, removal or deportation does take place. The average length of stay per detainee is approximately 35 days.

The Houston Processing Center employs 321 full-time staff.

The facility is a one-story, single building facility encompassing 182,786 square feet. The detainee housing area consists of 26 dormitories that house from 20 to 60 detainees; a four cell female segregation unit; a 32 cell male segregation unit and a 16 bed medical short stay unit that includes negative air pressure cells. All dormitories have large dayroom area with tables, chairs, microwaves, televisions, Play Station video game systems and a variety of board games. The entire facility has temperature control capabilities, for both heating and cooling.

D. Pre-Audit Meeting

The team met on June 10, 2019 in Houston, to discuss the information provided by the Association staff and the officials from Houston Processing Center.

AMERICAN OVERSIGHT

The chairperson divided standards into the following groups:

Standards #1-A-01 to #4-B-09 (b)(6); (b)(7)(C) Member
Standards #4-C-01 to #4-D-28 (b)(6); (b)(7)(C) Medical Member
Standards #5-A-01 to #7 -7-07 (b)(6); (b)(7)(C) Chairperson

E. The Audit Process

1. Transportation

The team was escorted to and from the facility by (b)(6); (b)(7)(C) Quality Assurance Manager.

2. Entrance Interview

The audit team proceeded to the office of Warden Robert Lacey Jr. at 7:45 a.m. The team expressed the appreciation of the Association for the opportunity to be involved with HPC in the accreditation process.

The audit team proceeded to the large training room by Warden Lacey. The team spoke to the staff who gathered for this opening briefing and explained the ACA process. We told them that we look forward to meeting them in their work area and having them explain what part they play in the ACA process.

The following persons were in attendance:

ACA Audit Entrance Meeting
June 10, 2019

(b)(6); (b)(7)(C)	Food Service Administrator
	Classification Coordinator
	Maintenance Supervisor
	STG Coordinator
	PHS
	PHS
	Administrative Clerk
	Recreation Supervisor
	Shift Supervisor
	Detention Officer
	Chief of Unit Management
	Detention Officer
	Quality Assurance Manager
	Quality Assurance Coordinator
	Personnel Investigator
	Safety Manager
	Learning & Development Manager

AMERICAN OVERSIGHT

(b)(6); (b)(7)(C)	Warehouse Worker Investigator ICE / COR Facility Manager, Operations Finance Secretary Unit Manager Sr. Detention Officer Classification Officer

It was explained that the goal of the visiting team was to be as helpful and non - intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The team toured the entire facility from 8:30 a.m. to 11:30 a.m. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

1.	(b)(6); (b)(7)(C)	Warden
2.		COUM (Acting Assistant Warden)
3.		Admin Shift Supervisor
4.		Quality Assurance Manager
5.		Quality Assurance Coordinator

Facility notices were posted throughout the facility.

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security:

All persons, including administrative staff, entering or exiting the facility are required to enter through a metal detector and all items were searched during the entry process. All visitors entering the facility are logged in and out of the facility. Only approved items can be brought into the facility.

(b)(7)(E)

AMERICAN OVERSIGHT

(b)(7)(E)

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(b)(7)(E)

The warehouse was very clean and well taken care of. After checking all inventories this auditor found the chemical log off by one bottle. The warehouse supervisor found out what had happened and found the missing chemical. Someone from the kitchen had taken the item over the weekend and had forgotten to check out the chemical. A memo was put out explaining the proper procedure.

Environmental Conditions:

All housing areas had very good ventilation with no noticeable odors or collections of dust in the vent openings. There were appropriate numbers of showers that were easily accessible to the offenders.

The day room space provided enough space for offenders to program in both leisure and structured programs. The space is well maintained, clean, provides for both seating and table space, offers television. The day room space is monitored on the floor by roving officers. The space is quiet, and well managed.

The temperatures of the facility were within normal comfort ranges and lighting was adequate. Noise and lighting levels all met the standard requirements.

Sanitation:

The facility was clean and well maintained. Staff and even offenders took pride in keeping the sanitation high. This demonstrates the facility's commitment to providing for a high quality of life and conditions of confinement.

Each offender is provided clothing, undergarments, linen, personal hygiene and other materials required to maintain enough hygienic standards. Cleaning supplies are available for offenders as needed. Additional hygiene items are also available through the commissary.

Fire Safety:

The facility has a designated Fire and Safety Officer who inspects all fire and safety equipment and maintains an accurate inventory of all fire and safety equipment. A thorough inspection was completed of all fire and safety equipment. The facility fire systems were inspected as required by local and state governmental regulations and ACA standards. Fire extinguishers, SCBAs, first aid kits and AED were placed in locations affording staff timely access in emergency situations where such items would be needed.

Staff report any safety concerns and the facility addresses any issues immediately.

AMERICAN OVERSIGHT

While touring the facility, wet floor signs were used as required. All areas were clean and clear of any trip hazards or debris. There were no deficiencies regarding fire and safety identified during this audit.

Food Service:

The food service areas were clean and well organized for the number of detainees and meals served. The space provided and equipment used was appropriate for the size of the facility.

The food service tool and equipment inventory are conducted and verified during the Audit. In addition, the facility utilizes a shadow board inventory identification system which easily identifies any item which is currently being used. All utensils were engraved with a numerical identification number.

All staff and inmates were appropriately trained for working in the food service area. Staff had completed the Serve Safe Certification program in addition to all other training provided.

All coolers and freezers were well organized. Temperatures were within requirements and documented daily. Food service supplies are neatly organized and rotated appropriately.

Food temperatures were checked regularly and were properly documented. During the Audit, the team spot checked the food temperatures while the tray line was running. All temperatures were appropriate and consistent with the logged documentation.

Medical Care:

The Houston Processing Center provides medical services through Immigration and Health Corps (IHSC) and contractually with STGI. (b)(7)(E)

(b)(7)(E)

The clinic has the following areas to provide medical services: four exam rooms, two triage rooms, waiting/hold area, an urgent care room, and four negative air flow cells. These cells will have coverings if a male and a female detainee both need to be housed there.

Previously this operation had a medical unit which could house up to four patients in a room. This has changed; these rooms are now used for detainee overflow.

AMERICAN OVERSIGHT

Sick call services are available seven days a week. Detainees sign up daily per an announcement in the unit and are seen typically the next morning, but no later than 48 hours. There is no co-pay charge for the services. History and Physicals are conducted within 14 days as required. Chronic care clinics are established as needed (cardiology, hypertension, hyperlipidemia, pulmonology, infectious disease, Coumadin therapy, obstetrics/gynecology, etc.).

Upon intake, a medical screening, which includes a chest x-ray, is conducted. All females receive a pregnancy test prior to getting the chest x-ray. Staff report that x-ray results are typically returned within an hour; interpreted by a radiologist from the University of Maryland. Detainees are also screened for infectious diseases. Lionbridge interpreter service is available for communication barriers. There is also a backup service if needed (Interpret Talk). Education is provided regarding Tb, access to medical care, how to file a grievance, women's health, staying healthy, dealing with stress in addition to other general education. Pictures are used when relevant to help assist with communication with the material.

An electronic medical record is utilized which contains all required reports. Documents (such as the medication administration record) are scanned into the record. Detainees who leave are provided with a code to access their medical record upon release.

Medications are administered five times per day. This includes blood sugar testing and insulin shots. One medication line is designated for issuing keep on person (KOP) medications. Medications may be crushed upon orders of the provider. As noted, there is a full time Pharmacist and two pharmacy technicians who manage the medications and pharmacy operations. Medications are received from McKesson. They are received in storage bins with a secured seal. Upon receipt, the items are reconciled with the orders and the medications received. By having the Pharmacy on site, medications prescribed can be dispensed as quick as one hour. Narcotics controls were observed, and one item checked for accuracy. Records were in good order. Detainees can purchase commissary items in the store as well. They include hydrocortisone cream, hemorrhoid ointment, muscle rub, low dose aspirin, cough drops, eye drops, antifungal powder, anti-fungal cream, milk of magnesia, and gel insoles. Upon discharge, medication supplies are provided to the detainees, a seven to 30-day supply based on the nature of the need.

There is a room for obtaining blood samples which is drawn by the nurse. Sharps and tools were stored in this area. Counts and records were checked and found to be accurate. The facility uses LabCorp to conduct their test. Results are received electronically and signed off electronically by the physician.

As noted, there are radiology services on site. Digital x-rays are taken and performed by x-ray technicians. If an x-ray needed arises that cannot be taken at this operation, the detainee would be transferred off site.

AMERICAN OVERSIGHT

Specialty care is provided off site. It includes the following: cardiology, gastroenterology (including colonoscopy/endoscopy needs), general surgery, nephrology, neurology, obstetrics/gynecology, ophthalmology, oral surgery, orthopedic, otorhinolaryngology, physical therapy, podiatry, and infectious disease.

Medical diets are coordinated with the food service operation with the use of a contractual dietician. Medical diets include, a Diet for Health, renal diet, diabetic diets (with snacks) in addition to others as needed. The medical staff provides the appropriate clearance before detainees can work in the food service area.

Emergency services are provided using eight local hospitals are available to meet needs outside the medical clinic, for specialty care and emergencies. There is a psychiatric center used by this facility (when needed) and dialysis services. All staff is Basic Life Services (BLS) trained annually. First aid kits are available in the restrictive housing areas (maintained by the Safety office). Three AED's are located at this facility (two with the emergency medical bags, one in a third area). There is a contract with the local ambulance company to provide emergency transportation. There is a physician, mental health person and access to dental staff available 24/7.

Detainees who are going to be placed in the restrictive housing unit are screened by medical staff, in the medical clinic prior to placement. Nursing staff visit the operation daily for sick call as well as dispense medications as required.

Dental services are provided on site in a Dental Clinic. There is one full time dentist and one full time dental assistant. Panoramic digital x-rays are taken as determined medically. Dental medications are ordered through the electronic medical record which affords review by the pharmacy before dispensing. Sterilization and decontamination procedures are in place. Medical instrument as well as dental instrument sterilization is processed by the dental staff. Tools and needles are well controlled; an inventory was randomly checked and found to comply. Records reflected detailed records of maintaining tools and needles.

Mental health services are provided by (b)(7)(E) licensed mental health staff. (b)(7)(E)
(b)(7)(E)
shortly. In the interim, tele psychiatry is used. Mental health staff provides the following services: intake screening, PREA assessment, crisis intervention, individual therapy and supportive psychotherapy. This department visits the restrictive housing unit at least weekly, more often if needed. The suicide observation room is in restrictive housing. The appropriate suicide blankets and attire are available should the situation warrant its use.

Quality Assurance and performance improvement activities are ongoing. Staff meets quarterly with the Warden and provides appropriate statistical information in addition to a unique medical need that have presented.

AMERICAN OVERSIGHT

Equipment is regularly checked for accuracy and calibrating. Stickers documenting this were available on all medical equipment checked during the audit. Refrigerator temperatures are monitored daily. A system is in place to ensure the emergency bag is always in a "ready" state. Medical supplies were sufficiently stock and well organized to easily retrieve the item needed. Biohazard waste is collected by Stericycle regularly and more often if needed.

Recreation:

HPC provides, at least one hour of outdoor recreation daily, weather permitting, in spacious and well-equipped areas, one for males and one for females. In addition, both females and males have their own indoor facility, which again are available during inclement weather and likewise have a more than adequate amount of exercise equipment. Outdoor activities include basketball, soccer, handball, track/walking, and cardiovascular equipment. Indoor activities include table tennis, exercise bikes, elliptical machines and other such apparatus. The team observed all these areas being utilized during the tour except the female gym due to a new carpet being installed. Play Station is also available and donated craft items were seen being used to devise creative items. The male segregation unit had a caged area in the dayroom with games, a TV, portable phone, and a legal reference computer. In addition, just outside, there were four large outdoor exercise cages, which they are permitted to access for an unusual two hours day.

The facility makes use of recreation/exercise and leisure time activities to occupy the detainee's day since there is no other formal structured programming. At least two televisions are in each dayroom, one Spanish and one English with basic cable channels available. In addition, there is a TV specifically designated for movies which are shown on a regular basis. Even the segregation units have TV's. There are plentiful board games and cards accessible in the dayrooms during almost all but sleeping hours.

Recreation for detainees in segregation have one-hour recreation on disciplinary status seven days a week one hour. Detainees on Administrative Segregation receive two hours of recreation time seven days per week.

Religious Programming:

The program is supervised by a full-time chaplain who also volunteers representing all the major faiths requested by the detainee population.

Religious services include counseling, group prayer, bible study, and different religious organization church and worship services.

The chapel is neat and appropriate for the population. Religious materials are available upon request, inclusive of religious literature, and religious diets are provided as approved by the chaplain.

AMERICAN OVERSIGHT

Religious services and programs are provided seven days a week according to a published and posted schedule. The volunteers total approximately 145 including representatives of the Baptist, Islamic, Catholic and other Protestant faiths. Given the composition of most of the detainee population, almost 2/3 of the volunteers are Catholic. The chaplain also coordinates educational programs as well as Life Skills videos on anger management and domestic violence.

Offender Work Programs:

Detainees are not assigned internal work assignments unless they volunteer and meet the criteria, including a medical clearance and ability to understand the designated duties and requirements. Each detainee receives training and orientation before assignment. The jobs primarily include kitchen workers, laundry, commissary, barbers, and dormitory porters/sanitation workers. No detainee workers are employed outside the buildings and there are no community work projects using detainee labor.

Academic and Vocational Education:

The Unit does not offer traditional educational programs and no vocational programming at all, primarily due to the transient nature and legal status of the detainee population. However, a "Know Your Rights" / Legal Orientation Program, provided by volunteer legal representatives, is offered twice weekly for all detainees.

Social Services:

There is no formal substance abuse or other such services, the facility utilizes the Unit Management concept and has counselors readily available to address crisis situations as well as routine needs/request. Detainees are also provided with a PREA/Victim Advocate to address issues and concerns regarding sexual abuse and assault. ICE Health Services provides psychological and psychiatric services as determined. AIDS/HIV testing and educational services are available upon request. The Chaplain is available for pastoral counseling as needed.

Detainees Drug Awareness, thinking for a Change and Anger Management programming is available through the chaplain or case managers.

Visitation:

The visitation area is comprised of 15 non-contact stations with glass partitions and phone communication and one caged area for segregation visitation. No contact visits are allowed.

AMERICAN OVERSIGHT

Visiting hours are from 7:00 a.m. to 5:00 p.m. seven days a week according to a posted schedule. Detainees are permitted one visit per week for up to one hour from up to two adults and two minor children at a time. There are provisions for special and extended visits as determined by the Chief of Security. The team found the area to be spacious, clean and orderly.

Library Services:

HPC provides a general and legal library services for males and females in separate locations daily including weekends according to set schedules. Extended law library access is available upon request and with a pass. Detainees with verified court deadlines will be given priority. The male section is open from 7:00 a.m. to 5:15 p.m. and the female area is operational from 7:00 a.m. to 9:15 a.m. and then again from 6:00 p.m. to 10:30 p.m. Segregation and Short Stay Unit housing areas are afforded the opportunity to choose from a leisure reading cart and a portable computer station with electronic legal material is made available upon request. Three general reading books may be checked out for seven days whereas reference materials, legal materials and magazines may not be removed from the library. Computers are available in the Law Library for preparation of legal documents only. Printers are provided for legal documents as well. Though small, the respective libraries were well organized and equipped.

Laundry:

The facility operates two separate laundry centers. There is one laundry center located in the male housing area and one laundry center located in the female housing area. (b)(7)(E) Inmate workers are assigned on a voluntary basis to work in the laundry centers. Laundry Centers were very clean and well organized. Inmates are provided all necessary laundry items. All laundry was changed daily.

F. Examination of Records

Following the facility tour, the team proceeded to the Accreditation conference room to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has zero notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

Over the last three years, the facility had zero consent decrees, class action lawsuits or adverse judgments.

AMERICAN OVERSIGHT

2. Significant Incidents/Outcome Measures

These were reviewed for the previous 12 months. Overall, they reflect few areas of concern. Medical Outcomes reflects two active Tb cases, which is normal given the population. Emergency transports reportedly reflect such cases as appendicitis, chest pain, etc. the number of medical diets reflects the numbers prescribed; they appear high but not when considering the transient nature of the population.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

Department revisited	Person(s) Contacted
Kitchen	(b)(6); (b)(7)(C)
Medical	
Warehouse	
Maintenance	

4. Shifts

a. Day Shift

The team was present at the facility during the day shift at 8:00 a.m. each day. Team members observed the lunch service, and visited all housing areas, speaking with staff in the units as well as the library and laundry services. On day one we toured the facility and met and spoke with all types of staff security and non-security.

b. Evening Shift - (b)(7)(E)

c. Night Shift

The team was present at the facility during the evening shift from 5:30 p.m. p.m. to 6:30 p.m. on the second day of the audit. The team watched the change of shift proceedings and interviewed and interacted with as many of the oncoming officers when possible, as well as several off going officers.

5. Status of Previously Non-compliant Standards/Plans of Action

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

HPS was granted a waiver last audit for 1-A-15.

AMERICAN OVERSIGHT

G. Interviews

During the audit, team members met with both staff and offenders to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interviews

The team spoke to about 30 inmates. All inmates felt safe at this unit. All but one had good comments about medical and food service. Some of the inmates spoke English but we had an interpreter if needed.

Ten female detainees were interviewed as well. Overall, they were complimentary of the operations. Areas they wanted improvement would be to have more soap available to them and food portions are small. Inmates on all the shift indicated they see the Warden and other executive staff regularly.

2. Staff Interviews

The team spoke to about 40 staff, both security and non-security. All spoke well of the warden and his management team. No staff had any bad comments. They all felt safe and we were impressed by the number of years of service that the staff seem to have at this facility. Staff indicated they see the Warden and other executive staff regularly; the supervisor is readily available to them when needed.

H. Exit Discussion

The exit interview was held at 11:00 a.m. in the training room with the warden and 61 staff in attendance.

The following persons were also in attendance:

(b)(6); (b)(7)(C) ICE
(b)(6); (b)(7)(C) ICE

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

AMERICAN OVERSIGHT

AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Adult Local Detention Facilities, 4th Edition	
Supplement	2016 Standards Supplement	
Facility/Program	Houston Processing Center	
Audit Dates	June 10 - 12-2019	
Auditor(s)	(b)(6); (b)(7)(C) Chairperson (b)(6); (b)(7)(C) Member Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	60	323
Number Not Applicable	0	32
Number Applicable	60	291
Number Non-Compliance	0	0
Number in Compliance	60	291
Percentage (%) of Compliance	100%	100%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001140

COMMISSION ON ACCREDITATION FOR CORRECTIONS

CoreCivic
Houston Processing Center (CoreCivic)
Houston, Texas

June 10 - 12, 2019

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-1A-09

SINGLE CELLS IN GENERAL POPULATION PROVIDE AT LEAST 35 SQUARE FEET OF UNENCUMBERED SPACE. AT LEAST 70 SQUARE FEET TOTAL FLOOR SPACE IS PROVIDED WHEN THE OCCUPANT IS CONFINED FOR MORE THAN 10 HOURS PER DAY.

FINDINGS:

Facility has no single cells in unit.

Standard #4-ALDF-2A-36

INMATES PARTICIPATING IN WORK OR EDUCATIONAL RELEASE PROGRAMS ARE SEPARATED FROM INMATES IN THE GENERAL POPULATION.

FINDINGS:

Facility has not program/education.

Standard #4-ALDF-2A-37

CONFINEMENT OF JUVENILES UNDER THE AGE OF 18 IS PROHIBITED UNLESS A COURT FINDS THAT IT IS IN THE BEST INTEREST OF JUSTICE AND PUBLIC SAFETY THAT A JUVENILE AWAITING TRIAL OR OTHER LEGAL PROCESS BE TREATED AS AN ADULT FOR THE PURPOSES OF PROSECUTION, OR UNLESS CONVICTED AS AN ADULT AND REQUIRED BY STATUTE TO BE CONFINED IN AN ADULT FACILITY.

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FINDINGS:

No juveniles housed at the facility.

Standard #4-ALDF-2A-38

IF YOUTHFUL OFFENDERS ARE HOUSED IN THE FACILITY, THEY ARE HOUSED IN A SPECIALIZED UNIT FOR YOUTHFUL OFFENDERS EXCEPT WHEN:

- VIOLENT, PREDATORY YOUTHFUL OFFENDER POSES AN UNDUE RISK OF HARM TO OTHERS WITHIN THE SPECIALIZED UNIT, OR
- A QUALIFIED MEDICAL OR MENTAL-HEALTH SPECIALIST DOCUMENTS THAT THE YOUTHFUL OFFENDER WOULD BENEFIT FROM PLACEMENT OUTSIDE THE UNIT

A WRITTEN STATEMENT IS PREPARED DESCRIBING THE SPECIFIC REASONS FOR HOUSING A YOUTHFUL OFFENDER OUTSIDE THE SPECIALIZED UNIT AND A CASE-MANAGEMENT PLAN SPECIFYING WHAT BEHAVIORS NEED TO BE MODIFIED AND HOW THE YOUTHFUL OFFENDER MAY RETURN TO THE UNIT. THE STATEMENT OF REASONS AND CASE-MANAGEMENT PLAN MUST BE APPROVED BY THE FACILITY ADMINISTRATOR OR HIS/HER DESIGNEE. CASES ARE REVIEWED AT LEAST QUARTERLY BY THE CASE MANAGER, THE ADMINISTRATOR OR HIS OR HER DESIGNEE, AND THE YOUTHFUL OFFENDER TO DETERMINE WHETHER A YOUTHFUL OFFENDER SHOULD BE RETURNED TO THE SPECIALIZED UNIT.

FINDINGS:

No juveniles housed at the facility.

Standard #4-ALDF-2A-39

DIRECT SUPERVISION IS EMPLOYED IN THE SPECIALIZED UNIT TO ENSURE THE SAFETY AND SECURITY OF YOUTHFUL OFFENDERS.

FINDINGS:

No youthful offenders.

AMERICAN OVERSIGHT

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Standard #4-ALDF-2A-40

CLASSIFICATION PLANS FOR YOUTHFUL OFFENDERS DETERMINE LEVEL OF RISK AND PROGRAM NEEDS DEVELOPMENTALLY APPROPRIATE FOR ADOLESCENTS. CLASSIFICATION PLANS INCLUDE CONSIDERATION OF PHYSICAL, MENTAL, SOCIAL, AND EDUCATIONAL MATURITY OF THE YOUTHFUL OFFENDER.

FINDINGS:

No youthful offenders.

Standard #4-ALDF-2A-41

ADEQUATE PROGRAM SPACE IS PROVIDED TO MEET THE PHYSICAL, SOCIAL, AND EMOTIONAL NEEDS OF YOUTHFUL OFFENDERS AND ALLOWS FOR THEIR PERSONAL INTERACTIONS AND GROUP ORIENTED ACTIVITIES.

FINDINGS:

No youthful offenders.

Standard #4-ALDF-2A-42

YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT FOR YOUTHFUL INMATES HAVE NO MORE THAN INCIDENTAL SIGHT OR SOUND CONTACT WITH ADULT INMATES FROM OUTSIDE THE UNIT IN LIVING, PROGRAM, DINING, OR OTHER COMMON AREAS OF THE FACILITY. ANY OTHER SIGHT OR SOUND CONTACT IS MINIMIZED, BRIEF, AND IN CONFORMANCE WITH APPLICABLE LEGAL REQUIREMENTS.

FINDINGS:

No youthful offenders.

Standard #4-ALDF-2A-43

PROGRAM PERSONNEL WHO WORK WITH YOUTHFUL OFFENDERS ARE TRAINED IN THE DEVELOPMENTAL, SAFETY, AND OTHER SPECIFIC NEEDS OF YOUTHFUL OFFENDERS. WRITTEN JOB DESCRIPTIONS AND QUALIFICATIONS REQUIRE TRAINING FOR STAFF WHO ARE RESPONSIBLE FOR PROGRAMMING OF YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT BEFORE BEING ASSIGNED TO WORK WITH YOUTHFUL OFFENDERS. TRAINING INCLUDES, BUT IS NOT LIMITED TO THE FOLLOWING AREAS:

AMERICAN OVERSIGHT

- ADOLESCENT DEVELOPMENT
- EDUCATIONAL PROGRAMMING
- CULTURAL AWARENESS
- CRISIS PREVENTION AND INTERVENTION
- LEGAL ISSUES
- HOUSING AND PHYSICAL PLANT
- POLICIES AND PROCEDURES
- MANAGEMENT OF, AND PROGRAMMING FOR, SEX OFFENDERS
- SUBSTANCE-ABUSE SERVICES
- COGNITIVE BEHAVIORAL INTERVENTIONS, INCLUDING ANGER MANAGEMENT, SOCIAL-SKILLS TRAINING, PROBLEM SOLVING
- RESISTING PEER PRESSURE
- SUICIDE PREVENTION
- NUTRITION
- MENTAL-HEALTH ISSUES
- GENDER-SPECIFIC ISSUES
- CASE-MANAGEMENT PLANNING AND IMPLEMENTATION

FINDINGS:

No youthful offenders.

Standard #4-ALDF-2C-02

WHEN A CANINE UNIT IS OPERATED BY THE FACILITY:

- THERE IS A MISSION STATEMENT, INCLUDING GOALS AND OBJECTIVES
- THE CIRCUMSTANCES IN WHICH CANINE UNITS MAY BE USED ARE CLEARLY DEFINED
- EMERGENCY PLANS ARE INTEGRATED INTO THE OVERALL EMERGENCY PLANS OF THE FACILITY
- THERE ARE CRITERIA FOR SELECTING, TRAINING AND CARING FOR ANIMALS
- THERE ARE CRITERIA FOR THE SELECTION, TRAINING, AND PHYSICAL FITNESS OF HANDLERS
- THERE IS AN APPROVED SANITATION PLAN THAT COVERS INSPECTION, HOUSING, TRANSPORTATION AND DAILY GROOMING FOR THE ANIMALS
- THERE ARE DAILY AND CURRENT RECORDS ON TRAINING, CARE OF DOGS AND SIGNIFICANT EVENTS

FINDINGS:

No canine units.

AMERICAN OVERSIGHT

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Standard #4-ALDF-4A-14

WHEN REQUIRED BY STATUTE, FOOD PRODUCTS THAT ARE GROWN OR PRODUCED WITHIN THE SYSTEM ARE INSPECTED AND APPROVED BY THE APPROPRIATE GOVERNMENT AGENCY; THERE IS A DISTRIBUTION SYSTEM THAT ENSURES PROMPT DELIVERY OF FOODSTUFFS TO FACILITY KITCHENS.

FINDINGS:

No produce grown.

Standard #4-ALDF-4D-10

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A WRITTEN AGREEMENT BETWEEN THE FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS THE SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS OR INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

Not used to perform any duties.

Standard #4-ALDF-5A-05

THERE IS A TREATMENT PHILOSOPHY WITHIN THE CONTEXT OF THE TOTAL CORRECTIONAL SYSTEM AS WELL AS GOALS AND MEASURABLE OBJECTIVES. THESE DOCUMENTS ARE REVIEWED AT LEAST ANNUALLY AND UPDATED AS NEEDED.

FINDINGS:

No programs in Houston.

Standard #4-ALDF-5A-06

THERE IS AN APPROPRIATE RANGE OF PRIMARY TREATMENT SERVICES FOR ALCOHOL AND OTHER SUBSTANCE-ABUSING INMATES THAT INCLUDE, AT A MINIMUM, THE FOLLOWING:

- INMATE DIAGNOSIS

AMERICAN OVERSIGHT

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- IDENTIFIED PROBLEM AREAS
- INDIVIDUAL TREATMENT OBJECTIVES
- TREATMENT GOALS
- COUNSELING NEEDS
- DRUG EDUCATION PLAN
- RELAPSE PREVENTION AND MANAGEMENT
- CULTURALLY SENSITIVE TREATMENT OBJECTIVES, AS APPROPRIATE
- THE PROVISION OF SELF-HELP GROUPS AS AN ADJUNCT TO TREATMENT
- PRERELEASE AND TRANSITIONAL SERVICE NEEDS
- COORDINATION EFFORTS WITH COMMUNITY SUPERVISION AND TREATMENT STAFF DURING THE PRERELEASE PHASE TO ENSURE A CONTINUUM OF SUPERVISION AND TREATMENT

FINDINGS:

No programs in Houston.

Standard #4-ALDF-5A-07

THE FACILITY USES A COORDINATED STAFF APPROACH TO DELIVER TREATMENT SERVICES. THIS APPROACH TO SERVICE DELIVERY IS DOCUMENTED IN TREATMENT PLANNING CONFERENCES AND IN INDIVIDUAL TREATMENT FILES.

FINDINGS:

No programs in Houston.

Standard #4-ALDF-5A-08

THERE ARE INCENTIVES FOR TARGETED TREATMENT PROGRAMS TO INCREASE AND MAINTAIN THE INMATE'S MOTIVATION FOR TREATMENT.

FINDINGS:

No programs in Houston.

Standard #4-ALDF-5A-10

IN FACILITIES OFFERING ACADEMIC AND VOCATIONAL TRAINING PROGRAMS, CLASSROOMS ARE DESIGNED IN CONSULTATION WITH SCHOOL AUTHORITIES. (RENOVATION, ADDITION, NEW CONSTRUCTION ONLY)

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FINDINGS:

No programs in Houston.

Standard #4-ALDF-5B-13

ALL INMATES HELD FOR 30 OR MORE DAYS WHO WILL BE RELEASED TO THE COMMUNITY ARE PROVIDED WITH PREPARATION FOR RELEASE THAT INCLUDES INFORMATION ABOUT COMMUNITY RESOURCES.

FINDINGS:

No direct community releases.

Standard #4-ALDF-5B-14

WHEN THE FACILITY IS DESIGNATED TO OPERATE ANY TYPE OF PRETRIAL INTERVENTION SERVICE OR OTHER RELEASE PROGRAMS, ITS AUTHORITY AND RESPONSIBILITY ARE STATED BY STATUTE OR ADMINISTRATIVE REGULATION.

FINDINGS:

No pre-trial.

Standard #4-ALDF-5B-15

WHEN A PRETRIAL INTERVENTION PROGRAM, DIVERSION PROGRAM, PRETRIAL RELEASE PROGRAM, OR SUPERVISED RELEASE PROGRAM IS CONDUCTED IN THE FACILITY, SUFFICIENT STAFF, SPACE, AND EQUIPMENT ARE PROVIDED TO SERVICE THE PROGRAM.

FINDINGS:

No pre-trial.

Standard #4-ALDF-5B-16

WHERE TEMPORARY RELEASE PROGRAMS EXIST, THE PROGRAMS HAVE THE FOLLOWING ELEMENTS:

- WRITTEN OPERATIONAL PROCEDURES
- CAREFUL SCREENING AND SELECTION PROCEDURES
- WRITTEN RULES OF INMATE CONDUCT
- A SYSTEM FOR EVALUATING PROGRAM EFFECTIVENESS

AMERICAN OVERSIGHT

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- EFFORTS TO OBTAIN COMMUNITY COOPERATION AND SUPPORT

FINDINGS:

No temp release.

Standard #4-ALDF-5B-17

WHERE WORK RELEASE AND/OR EDUCATIONAL RELEASE ARE AUTHORIZED, THE FACILITY ADMINISTRATOR HAS AUTHORITY TO APPROVE OR DISAPPROVE PARTICIPATION FOR EACH INMATE.

FINDINGS:

No educational/vocational.

Standard #4-ALDF-5C-07

The facility can require all sentenced inmates to work if they are not assigned to programs.

FINDINGS:

No sentenced inmates.

Standard #4-ALDF-5C-09

WHERE STATUTE PERMITS, INMATES ARE ASSIGNED TO PUBLIC WORKS AND COMMUNITY SERVICE PROJECTS.

FINDINGS:

No community service.

Standard #4-ALDF-5C-13

WHERE AN INDUSTRIES PROGRAM EXISTS, ITS ESTABLISHMENT IS AUTHORIZED AND AREAS OF AUTHORITY, RESPONSIBILITY, AND ACCOUNTABILITY ARE DELINEATED.

FINDINGS:

No industry.

AMERICAN OVERSIGHT

Standard #4-ALDF-5C-14

THE NUMBER OF INMATES ASSIGNED TO INDUSTRIES OPERATIONS MEETS THE REALISTIC WORKLOAD NEEDS OF EACH OPERATING UNIT.

FINDINGS:

No industry.

Standard #4-ALDF-5C-15

THERE IS A COMPREHENSIVE QUALITY CONTROL PROCESS.

FINDINGS:

No industry.

Standard #4-ALDF-5C-16

A COST ACCOUNTING SYSTEM FOR EACH INDUSTRIES UNIT IS DESIGNED, IMPLEMENTED, AND MAINTAINED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.

FINDINGS:

No industry.

Standard #4-ALDF-6B-06

APPROPRIATELY TRAINED INDIVIDUALS ARE ASSIGNED TO ASSIST DISABLED INMATES WHO CANNOT OTHERWISE PERFORM BASIC LIFE FUNCTIONS.

FINDINGS:

Detainees don't perform basic life action.

Standard #4-ALDF-7F-02

CONSISTENT WITH THE LAWS OF THE JURISDICTION, THERE IS A SYSTEM FOR PROVIDING NOTIFICATION TO THE REGISTERED VICTIM(S) OF A CRIME UPON THE RELEASE FROM CONFINEMENT OF THE CONVICTED INMATE OR IN THE EVENT OF AN ESCAPE. FOLLOW UP NOTIFICATION TO THE VICTIM(S) OCCURS WHEN ESCAPEES ARE RETURNED to custody.

AMERICAN OVERSIGHT

FINDINGS:

ICE does the report.

Standard #4-ALDF-7F-03

THE FACILITY ACTIVELY IDENTIFIES AND IMPLEMENTS ACTIVITIES THAT CONTRIBUTE TO THE COMMUNITY.

FINDINGS:

No community activities.

Standard #4-ALDF-7F-07

IF VOLUNTEERS ARE USED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTION, TRAINING, STAFF SUPERVISION, FACILITY ORIENTATION, AND A DEFINITION OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITY. VOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAINING. VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

Volunteers are not used for health care.

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Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Houston Processing Center
Reporting Period: Jun 2018 – May 2019

Incident Type	Months ⇨	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender/ Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		0	0	0	0	0	0	0	0	0	0	0	0	0	0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Name of Facility: Houston Processing Center
Date: 06/10/2019
Number of Months Data Collected: 12 (June 2018 - May 2019)

		ALDF Outcome Measures Worksheet		
Standard	**Outcome**	**Numerator/Denominator**	**Value**	**Calculated O.M.**
1A		**The community, staff, contractors, volunteers, and inmates are protected from injury and illness caused by the physical environment.**		
	(1)	Number of worker compensation claims filed for injuries that resulted from the physical environment in the past 12 months.	0.00	
	divided by	Average number of Full-Time Equivalent (FTE) staff positions in the past 12 months.	321.00	0.00%
	(2)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0.00	
	divided by	Average daily population in the past 12 months.	915.40	0.00%
	(3)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(5)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%
	(6)	Number of sanitation or health code violations identified by external agencies in the past 12 months.	0.00	

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	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(7)	Number of health code violations corrected in the past 12 months.	0.00	
	divided by	The number of health code violations identified in the past 12 months.	0.00	0.00%
	(8)	Number of inmate grievances related to safety or sanitation found in favor of inmates in the past 12 months.	0.00	
	divided by	The number of inmate's grievances related to safety or sanitation in the past 12 months.	1.00	0.00%
	(9)	Number of fire code violations corrected in the past 12 months.	0.00	
	divided by	The number of fire code violations cited by jurisdictional authority in the past 12 months.	0.00	0.00%
	(10)	Number of inmate injuries resulting from fires requiring medical treatment in a 12-month period.	0.00	
	divided by	The average daily population in the past 12 months.	915.400	0.00%
	(11)	Number of inmate injuries (other than by fire) requiring medical treatment in the past 12 months.	0.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.00%
	(12)	Number of staff injuries resulting from fires requiring medical treatment in the past 12 months.	0.00	
	divided by	The average daily population of staff in the past 12 months.	288.00	0.00%
	(13)	Number of staff injuries (other than fire) requiring medical treatment in the past 12 months.	0.00	
	divided by	The average daily population of staff in the past 12 months.	288.00	0.00%
	(14)	Number of inmate lawsuits related to safety or sanitation found in favor of the inmate in the past 12 months.	0.00	
	divided by	The number of inmate lawsuits related to safety or sanitation in the past 12 months.	0.00	0.00%
1B		Vehicles are maintained and operated in a manner that prevents harm to the community, staff, contractors, volunteers, and inmates.		

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	(1)	Number of vehicle accidents resulting in property damage in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of vehicle accidents resulting in injuries requiring medical treatment for any party in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(3)	Amount dollar of damage from vehicle accidents in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
1C		The number and severity of emergencies are minimized. When emergencies occur, the response minimizes the severity.		
	(1)	Number of emergencies, caused by forces external to the facility, that result in property damage in the past 12 months.	0.00	
	divided by	The number emergencies.	0.00	0.00%
	(2)	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(3)	Number of times that normal facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of hours that facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0.00	
	divided by	The number of emergencies caused by forces external to the facility.	0.00	0.00%
	(5)	Number of emergencies that were not caused by forces external to the facility that resulted in property damage in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%

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	(6)	Number of injuries requiring medical attention that resulted from emergencies that were not caused by forces external to the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(7)	Number of times that normal facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(8)	Number of hours that facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0.00	
	divided by	The number of emergencies.	0.00	0.00%
	(9)	Number of injuries resulting from fires requiring medical treatment in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(10)	Number of fires that resulted in property damage in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(11)	Amount dollar of property damage from fire in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(12)	Number of code violations cited in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(13)	Number of incidents involving toxic or caustic materials in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(14)	Number of incidents of inventory discrepancies in the past 12 months.	0.00	

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	divided by	The average daily population in the past 12 months.	915.40	0.00%
2A		The community, staff, contractors, volunteers, and inmates are protected from harm. Events that pose risk of harm are prevented. The number and severity of events are minimized.		
	(1)	Number of incidents involving harm in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of incidents in the past 12 months involving harm.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%
	(3)	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the incidents in the past 12 months.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%
	(5)	Number of unauthorized inmate absences from the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(6)	Number of instances of unauthorized access to the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
2B		Physical force is used only in instances of self-protection, protection of the inmate or others, prevention of property damage, or prevention of escape.		
	(1)	Number of instances in which force was used in the past 12 months.	18.00	
	divided by	The average daily population in the past 12 months.	915.40	0.11%
	(2)	Number of instances in which force was used in the past 12 months.	18.00	

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	divided by	The number of admissions in the past 12 months.	12876	0.02%
	(3)	Number of times that staff use of force were found to have been inappropriate in the past 12 months.	0.00	
	divided by	The number of instances in which force was used.	18.00	0.00%
	(4)	Number of inmate grievances filed alleging inappropriate use of force in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(5)	Number of grievances alleging inappropriate use of force decided in favor of inmate in the past 12 months.	0.00	
	divided by	The number of grievances alleging inappropriate use of force filed.	0.00	0.00%
	(6)	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
2C		Contraband is minimized. It is detected when present in the facility.		
	(1)	Number of incidents involving contraband in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of incidents involving contraband in the past 12 months.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%
	(3)	Number of weapons found in the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of controlled substances found in the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(5)	Number of controlled substances found in the facility in the past 12 months.	0.00	
	divided by	The number of admissions in the past 12 months.	12876	0.00%

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2D		Improper access to and use of keys, tools and utensils are minimized.		
	(1)	Number of incidents involving keys in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of incidents involving tools in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(3)	Number of incidents involving culinary equipment in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of incidents involving medical equipment and sharps in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
3A		Inmates comply with rules and regulations.		
	(1)	Number of rule violations in the past 12 months.	234	
	divided by	The average daily population in the past 12 months.	915.40	4.50%
	(2)	Number of assaults—inmate against inmate, inmate against staff in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
4A		Food service provides a nutritionally balanced diet. Food service operations are hygienic and sanitary.		
	(1)	Number of documented inmate illnesses attributed to food service operations in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of inmate grievances about food service decided in favor of the inmate the past 12 months.	0.00	
	divided by	The number of inmate grievances about food service in the past 12 months.	5	0.00%

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	(3)	Number of violations cited by independent authorities for food service sanitation in the past 12 months.	0.00	
	divided by	Number of violations cited by independent authorities in the past 12 months.	0.00	0.00%
4B		Inmates maintain acceptable personal hygiene practices.		
	(1)	Inmate grievances regarding inmate access to personal hygiene decided in favor of the inmate in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of inmate illnesses attributed to poor hygiene practices in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(3)	Number of inmates diagnosed with hygiene-related conditions (scabies, lice, or fungal infections) in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of inmate grievances related to hygiene found in favor of the inmate in the past 12 months.	0.00	
	divided by	The number of inmate grievances related to hygiene in the past 12 months.	0.00	0.00%
	(5)	Number of inmate lawsuits related to hygiene found in favor of the inmate in the past 12 months.	0.00	
	divided by	The number of inmate lawsuits related to hygiene in the past 12 months.	0.00	0.00%
5A		Inmates have opportunities to improve themselves while confined.		
	(1)	Number of inmates who passed GED exams while confined in the past 12 months.	0.00	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0.00	0.00%
	(2)	Total number of grade levels advanced by inmates in the past 12 months.	0.00	

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	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0.00	0.00%
	(3)	Number of certificates of vocational competency awarded to inmates in the past 12 months.	0.00	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0.00	0.00%
5B		Inmates maintain ties with their families and the community.		
		NONE		
5C		The negative impact of confinement is reduced.		
		NONE		
6A		Inmates' rights are not violated.		
	(1)	Total number of inmate grievances in the past 12 months, regarding: (a) access to court; (b) mail or correspondence; (c) sexual harassment; (d) discipline; (e) discrimination; (f) protection from harm.	8.00	
	divided by	The average daily population in the past 12 months.	915.40	0.009%
	(2)	Number of inmate grievances (see [a] through [e] above) decided in favor of inmates in the past 12 months.	3	
	divided by	The total number of grievances filed in the past 12 months.	84	0.04%
	(3)	Total number of inmate court suits alleging violation of inmate rights filed against the facility in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of inmate court suits alleging violation of inmate rights decided in favor of inmates in the past 12 months.	0.00	
	divided by	The total number of inmate suits filed in the past 12 months.	0.00	0.00%
6B		Inmates are treated fairly.		
	(1)	Number of inmate grievances regarding discrimination in the past 12 months.	0.00	

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	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(2)	Number of inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months.	0.00	
	divided by	The total number of inmate grievances filed regarding discrimination in the past 12 months.	0.00	0.00%
	(3)	Number of grievances resolved in favor of inmates in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of grievances resolved in favor of inmates in the past 12 months.	0.00	
	divided by	The total number of inmate grievances filed in the past 12 months.	84	0.00%
	(5)	Number of court malpractice or torte liability cases found in favor of the inmate in the past 12 months.	0.00	
	divided by	The number of court malpractice or torte liability cases in the past 12 months.	0.00	0.00%
6C		Alleged rule violations are handled in a manner that provides inmates with appropriate procedural safeguards.		
	(1)	Number of disciplinary incidents resolved informally in the past 12 months.	84	
	divided by	The average daily population in the past 12 months.	915.40	0.09%
	(2)	Number of formal inmate disciplinary decisions that were appealed in the past 12 months.	0.00	
	divided by	The total number of disciplinary decisions made in the past 12 months.	41.00	0.00%
	(3)	Number of appealed disciplinary decisions decided in favor of the inmate in the past 12 months.	0.00	
	divided by	The total number of disciplinary decisions made in the past 12 months.	41.00	0.00%
	(4)	Number of grievances filed by inmates challenging disciplinary procedures in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%

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	(5)	Number of disciplinary-related grievances resolved in favor of the inmate in the past 12 months.	0.00	
	divided by	The total number of disciplinary-related grievances filed in the past 12 months.	4	0.00%
	(6)	Number of court suits filed against the facility regarding discipline in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(7)	Number of court cases regarding discipline decided against the facility in the past 12 months.	0.00	
	divided by	The total number of court decisions regarding discipline decided in the past 12 months.	0.00	0.00%
	(8)	Number of rule violations in the past 12 months.	234	
	divided by	The average daily population in the past 12 months.	915.40	0.26%
	(9)	Number of inmates terminated from the facility due to rule violations in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
6D		Inmates take responsibility for their actions.		
	(1)	Number of inmates released in the past 12 months who made regular payments toward their restitution obligations.	0.00	
	divided by	The number of inmates who had restitution obligations in the past 12 months.	0.00	0.00%
	(2)	Number of inmates who satisfy their court cost/fines obligations in the past 12 months.	0.00	
	divided by	The number of inmates who had court cost/fine obligations in the past 12 months.	0.00	0.00%
	(3)	Total amount of restitution paid by inmates in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%

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	(4)	Total number of hours of community service donated by inmates in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(5)	Total number of inmates who participated in restitution in the past 12 months.	0.00	
	divided by	The total number of inmates housed in the past 12 months.	973	0.00%
	(6)	Total number of inmates who participated in community service work in the past 12 months.	0.00	
	divided by	The total number of inmates housed in the past 12 months.	973.40	0.00%
	(7)	Total number of inmates who participated in victim awareness programs in the past 12 months.	0.00	
	divided by	The total number of inmates housed in the past 12 months.	973.40	0.00%
	(8)	Total amount of restitution paid by inmates in the past 12 months.	0.00	
	divided by	The total number of inmates housed in the past 12 months.	973.40	0.00%
	(9)	Total number of hours delivered by inmates who participated in community service work in the past 12 months.	0.00	
	divided by	The total number of inmates housed in the past 12 months.	973.40	0.00%
7A		The facility operates as a legal entity.		
		NONE		
7B		Staff, contractors, and volunteers demonstrate competency in their assigned duties.		
	(1)	Total number of years of staff members' education as of the end of the last calendar year.	0.00	
	divided by	The number of staff at the end of the last calendar year.	314.00	0.00%
	(2)	Number of staff who left employment for any reason in the past 12 months.	14.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	4.36%

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	(3)	Total number of credit hours in course relevant to their facility responsibilities earned by staff participating in higher education in the past 12 months.	0.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	0.00%
	(4)	Number of professional development events attended by staff in the past 12 months.	7.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	2.18%
7C		Staff, contractors, and volunteers are professional, ethical and accountable.		
	(1)	Number of incidents in which staff was found to have acted in violation of facility policy in the past 12 months.	11.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	3.43%
	(2)	Number of staff terminated for conduct violations in the past 12 months.	2.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	0.62%
	(3)	Number of inmate grievances attributed to improper staff conducts which were upheld in the past 12 months.	0.00	
	divided by	The number of inmate grievances alleging improper staff conduct filed in the past 12 months.	6.00	0.00%
	(4)	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months.	0.00	
	divided by	The average daily population for the past 12 months.	915.40	0.00%
	(5)	Where staff is tested, the number of staff substance abuse tests failed in the past 12 months.	0.00	
	divided by	The number of staff substance abuse tests administered in the past 12 months.	9.00	0.00%

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	(6)	Number of staff terminations for violation of drug-free work policy in the past 12 months.	0.00	
	divided by	The number of staff terminations in the past 12 months.	11.00	0.00%
	(7)	The average number of physicians employed in the past 12 months.	0.00	
	divided by	The number of physician positions authorized in the past 12 months.	0.00	0.00%
	(8)	The average number of nurses employed in the past 12 months.	0.00	
	divided by	The number of nurse positions authorized in the past 12 months.	0.00	0.00%
	(9)	The average number of mid-level health care practitioners employed in the past 12 months.	0.00	
	divided by	The number of mid-level health care practitioner positions authorized in the past 12 months.	0.00	0.00%
	(10)	The average number of ancillary health care staff employed in the past 12 months.	0.00	
	divided by	The number of ancillary health care staff positions authorized in the past 12 months.	0.00	0.00%
7D		The facility is administered efficiently and responsibly.		
	(1)	Net amount of budget shortfalls or surplus at the end of the last fiscal year (budget less expenditures).	0.00	
	divided by	The budget for the past 12 months.	0.00	0.00%
	(2)	Number of material audit findings by an independent financial auditor at the conclusion of the last audit.	0.00	
		NONE		
	(3)	Number of grievances filed by inmates regarding their records or property in the past 12 months.	0.00	
	divided by	The average daily population in the past 12 months.	915.40	0.00%
	(4)	Number of inmate grievances (records/property) decided in favor of inmates in the past 12 months.	0.00	

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	divided by	The total number of inmate grievances (records/property) in the past 12 months.	0.00	0.00%
	(5)	Number of objectives achieved in the past 12 months.	3.00	
	divided by	The number of objectives for the past 12 months.	4.00	0.75%
	(6)	Number of program changes made in the past 12 months.	0.00	
	divided by	The number of program changes recommended in the past 12 months.	0.00	0.00%
	(7)	Number of problems identified by internal health care review that were corrected in the past 12 months.	0.00	
	divided by	The number of problems identified by internal health care review in the past 12 months.	0.00	0.00%
7E		Staff are treated fairly.		
	(1)	Number of grievances filed by staff in the past 12 months.	0.00	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	321.00	0.00%
	(2)	Number of staff grievances decided in favor of staff in the past 12 months.	0.00	
	divided by	The total number of staff grievances in the past 12 months.	0.00	0.00%
	(3)	Total number of years of staff members' experience in the field as of the end of the last calendar year.	0.00	
	divided by	The number of staff at the end of the last calendar year (e.g. average number of years' experience).	283.00	0.00%
	(4)	Number of staff termination or demotion hearings in which the facility decision was upheld in the past 12 months.	0.00	
	divided by	The number of staff termination or demotion hearings requested in the past 12 months.	0.00	0.00%
7F		The facility is a responsible member of the community.		
	(1)	Total number of hours of volunteer service delivered by members of the community in the past 12 months.	1,200.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	13.11%

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	(2)	Total number of individual community members who provided voluntary service in the past 12 months.	596.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.65%
	(3)	Total number of complaints filed by media regarding access to information in the past 12 months.	0.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.00%
	(4)	Total number of positive statements made by media regarding the facility in the past 12 months.	0.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.00%
	(5)	Total number of complaints from the community in the past 12 months.	0.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.00%
	(6)	Total number of hours of community service work delivered by inmates in the past 12 months.	0.00	
	divided by	The average daily population of inmates in the past 12 months.	915.40	0.00%

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DHS-ICE-20-0618-A-001167

IHSC MEDICAL OUTCOME MEASURES (2019)

4C		Inmates maintain good health. Inmates have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner.		
	(1)	Number of inmates with a positive tuberculin skin test in the past 12 months.	68	
	divided by	The number of admissions in the past 12 months.	4,677	0.015%
	(2)	Number of inmates diagnosed with active tuberculosis in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	911.60	0.002%
	(3)	Number of conversions to a positive tuberculin skin test in the past 12 months.	0	
	divided by	The number of tuberculin skin tests given in the past 12 months.	68	0.00%
	(4)	Number of inmates with a positive tuberculin skin test who completed prophylaxis treatment for tuberculosis in the past 12 months.	0	
	divided by	The number of inmates with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months.	50	0.00%
	(5)	Number of Hepatitis C positive inmates in the past 12 months.	18	
	divided by	The average daily population in the past 12 months.	911.60	0.03%
	(6)	Number of HIV positive inmates in the past 12 months.	53	
	divided by	The average daily population in the past 12 months.	911.60	0.06%
	(7)	Number of HIV positive inmates who are being treated with highly active antiretroviral treatment in the past 12 months.	51	

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	divided by	The number of known HIV positive inmates in the past 12 months.	53	0.96%
	(8)	Number of offenders with an individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time.	25	
	divided by	The average daily population in the past 12 months.	911.60	0.03%
	(9)	Number of inmate suicide attempts in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(10)	Number of inmate suicides in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(11)	Number of inmate deaths due to homicide in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(12)	Number of inmate deaths due to injuries in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(13)	Number of medically expected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(14)	Number of medically unexpected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(15)	Number of inmate admissions to the infirmary (where available) in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(16)	Number of inmate admissions to off-site hospitals in the past 12 months.	24	
	divided by	The average daily population in the past 12 months.	911.60	0.03%

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DHS-ICE-20-0618-A-001169

	(17)	Number of inmates transported off-site (via an ambulance or correctional vehicle) for treatment of emergency health conditions in the past 12 months.	228	
	divided by	The average daily population in the past 12 months.	911.60	0.03%
	(18)	Number of inmate specialty consults completed in the past 12 months.	437	
	divided by	The number of specialty consults (on-site or off-site) ordered by primary health care provider (MD, NP, PA) in the past 12 months.	437	1
	(19)	Number of inmate grievances about access to health care services found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate grievances about access to healthcare services in the past 12 months.	0	0.00%
	(20)	Number of inmate grievances related to the quality of health care found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate grievances related to the quality of health care in the past 12 months.	13	0.00%
	(21)	Number of inmates' lawsuits about access to healthcare services found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate's lawsuits about access to healthcare services in the past 12 months.	0	0.00%
	(22)	Number of individual sick call encounters in the past 12 months.	8240	
	divided by	The average daily population in the past 12 months.	911.60	9.04%
	(23)	Number of physician visits contacts in the past 12 months.	246	
	divided by	The average daily population in the past 12 months.	911.60	0.03%
	(24)	Number of individualized dental treatment plans in the past 12 months.	63	
	divided by	The average daily population in the past 12 months.	911.60	0.07%

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DHS-ICE-20-0618-A-001170

	(25)	Number of hypertensive inmates enrolled in a chronic care clinic in the past 12 months.	862	
	divided by	The average daily population in the past 12 months.	911.60	0.95%
	(26)	Number of diabetic inmates enrolled in a chronic care clinic in the past 12 months.	1601	
	divided by	The average daily population in the past 12 months.	911.60	1.76%
	(27)	Number of incidents involving pharmaceuticals as contraband in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	911.60	0.00%
	(28)	Number of cardiac diets received by inmates with cardiac disease in the past 12 months.	36	
	divided by	The number of cardiac diets prescribed in the past 12 months.	36	1
	(29)	Number of hypertensive diets received by inmates with hypertension in the past 12 months.	862	
	divided by	The number of hypertensive diets prescribed in the past 12 months.	862	1
	(30)	Number of diabetic diets received by inmates with diabetes in the past 12 months.	1601	
	divided by	The number of diabetic diets prescribed in the past 12 months.	1601	1
	(31)	Number of renal diets received by inmates with renal disease in the past 12 months.	65	
	divided by	The number of renal diets prescribed in the past 12 months.	65	1
	(32)	Number of needle-stick injuries in the past 12 months.	0	
	divided by	The number of employees on average in the past 12 months.	52	0.00%
	(33)	Number of pharmacy dispensing errors in the past 12 months.	0	
	divided by	The number of prescriptions dispensed by the pharmacy in the past 12 months.	16928	0.00%

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	(34)	Number of nursing medication administration errors in the past 12 months.	0	
	divided by	The number of medications administered in the past 12 months.	4982	0.00%
4D		Health services are provided in a professionally acceptable manner. Staff are qualified, adequately trained, and demonstrate competency in their assigned duties.		
	(1)	Number of staff with lapsed licensure and/or certification in the past 12 months.	0	
	divided by	The number of licensed or certified staff in the past 12 months.	48	0.00%
	(2)	Number of new employees in the past 12 months who completed orientation training prior to undertaking job assignments.	15	
	divided by	The number of new employees in the past 12 months.	15	1
	(3)	Number of employees completing in-service training requirements in the past 12 months.	52	
	divided by	The number of employees eligible in the past 12 months.	52	1
	(4)	Number of MD staff who left employment in the past 12 months.	1	
	divided by	The number of authorized MD staff positions in the past 12 months.	2	0.50%
	(5)	Number of RN staff who left employment in the past 12 months.	3	
	divided by	The number of authorized RN staff positions in the past 12 months.	18	0.17%
	(6)	Number of LPN staff who left employment in the past 12 months.	1	
	divided by	The number of authorized LPN staff positions in the past 12 months.	4	0.25%
	(7)	Number of medical records staff who left employment in the past 12 months.	1	
	divided by	The number of medical records staff positions in the past 12 months.	4	0.25%

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	(8)	Number of alleged sexual misconduct incidents between staff and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%
	(9)	Number of alleged sexual misconduct incidents between volunteers and/or contract personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%
	(10)	Number of confirmed sexual misconduct incidents between staff and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%
	(11)	Number of confirmed sexual misconduct incidents between volunteers and/or contact personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%
	(12)	Number of detainees identified as high risk with a history of sexually assaultive behavior in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%
	(13)	Number of detainees identified as at risk for sexual victimization in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	911.60	0.00%

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FOUNDED 1870

ORGANIZATION SUMMARY

Please complete a separate summary for each agency or facility and return to the ACA.

Name of Facility (Formal IHSC Name): Stewart DetentionCenter

Physical Address: 79 Holder Road, Lumpkin, GA 31815

Mailing Address (if different from above):

Primary IHSC Facility Telephone Number: (229) 838-(b)(6); (b)(7)(C)

Parent Agency: ICE Health Service Corps

Parent Facility Name:

Standards manual that will be used to obtain accreditation:

Performance Based Healthcare for ACI ☐ ALDF (HC Standards Only) ☐

**ACA does not currently have a stand-alone Performance Based Healthcare for ALDF manual

Accreditation Status: Initial ☒ Reaccreditation ☐

Date of last accreditation (if applicable): 8/17/2015

Airport Preferences:

1st Preference: Columbus Airport

Distance from the facility: 45 miles Miles

2nd Preference N/A

Distance from the facility: N/A Miles

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State the mission of the agency or facility (attach additional pages if necessary): :

Age range of the Population

Adults 35 Juveniles 0 Youthful Offenders 0

*Youthful offenders are under the age of majority but adjudicated as adults.

If this agency or facility accredited by any other organization? Yes ☒ No ☐

If yes, please provide the name of the organization(s) and the date(s) of the most recent accreditation: NCCHC-January 31, 2018

Does the agency have any court orders or litigation? Yes ☐ No ☒

If so, how many? _____

Please explain the court orders or litigation. You may attach copies of appropriate documents:

HUMAN RESOURCES

IHSC Administrator (if applicable): _____

Title: _____

Telephone Number _____

E-mail Address: _____

Existing ACA Member: Yes ☐ No ☐

ACA Membership Number: _____

IHSC Accreditation Manager (if applicable): _____

Title: Medical Compliance Officer

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Telephone Number: 229-838-(b)(6); (b)(7)(C)

E-mail Address: (b)(6); (b)(7)(C)

Existing ACA Member: Yes ☐ No ☒

ACA Membership Number: _____

Health Service Administrator: CAPT (b)(6); (b)(7)(C)

Title: Health Services Administrator

Telephone Number: Number(202) 321-(b)(6); (b)(7)(C)

E-mail Address (b)(6); (b)(7)(C)

Existing ACA Member: Yes ☒ No ☐

ACA Membership Number: _____

IHSC Program Manager: (b)(6); (b)(7)(C)

Title: Management And Program Analyst

Telephone Number: 202-732-(b)(6); (b)(7)(C)

E-mail Address (b)(6); (b)(7)(C)

Existing ACA Member: Yes ☐ No ☒

ACA Membership Number: _____

Total number of full-time staff by category:

Medical: (b)(7)(E) Administrative support: (b)(7)(E) Program: (b)(7)(E) Other: N/A

Total number of part-time staff by category:

Medical: (b)(7)(E) Administrative support: _____ Program: _____ Other: N/A

Shifts:

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(b)(7)(E)

- (b)(7)(E)
-
-
-

Admin Shift:

- Hours: : 7am-3:30pm
- Number of employees on shift: (b)(7)(E)

SECURITY AND OPERATIONAL FEATURES

Security level of the facility:

Maximum ☐ Medium ☒ Minimum ☐

Security level of the satellite facility (if applicable):

Maximum ☐ Medium ☐ Minimum ☐

Number of offenders by custody:

Maximum 609 Medium 546 Minimum 741

Type of campus:

Open ☐ Secured Enclosed ☒ Other ☐ Explain: _____

(b)(7)(E)

Cameras

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- (b)(7)(E)
-
-
-

Describe how movements are coordinated with the facility: High security detainees are always escorted. 25 detainees are served at a time for meals. Detainees are escorted to medical for appointments.

(b)(7)(E)

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Is Drug Testing managed by the IHSC: Yes ☐ No x☒

The only time that medical would do drug testing is if the detainee develops medical problem due to drug used.

What Drug testing procedures do you use: N/A

Inmates-system of testing & frequency: N/A

Brand name of field test & name of outside lab: N/A

Employees-system of testing & frequency: N/A

Brand name of field test & name of outside lab, if different: N/A

Explain the system in place for storing and dispensing medication: Pill line is conducted in housing units (b)(7)(E) OTC meds are in stored in locked drawers in sick call rooms. OTC are given by RN's during sick call as needed using directions in RN guidelines. Medications are stored in pharmacy where the pharmacy is locked 24 hours a day. Night stock meds are secured under coded lock in cabinet located in treatment room. Narcotics are kept in boxes under lock and key in pharmacy and medication room.

What company provides the drugs? McKesson

How many pill lines? 4

Are there narcotics or controlled medications and how are they controlled? Narcotics are stored in boxes under lock and key located in pharmacy and medication room. They are administered by LPN's and RN's during pill line.

Which staff members are responsible for receiving and delivering them? Pharmacist and pharmacy techs

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Signature: (b)(6); (b)(7)(C)

Title: Health Services Administartor
ICE Health Service Corps
Stewart Detention Center

Printed Name: _____

Date: 2/8/2018

Revised February 8, 2018

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE INITIAL AUDIT

ICE Health Service Corps (IHSC)
El Paso Processing Center
El Paso, Texas

November 5-6, 2018

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C) Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The audit of the ICE Health Service Corps (IHSC) at the El Paso Processing Center (EPC), El Paso, Texas was conducted on November 5-6, 2018 utilizing the American Correctional Association (ACA) Standards for Performance Based, Health Care for Adult Local Detention Facilities, 4th Edition and the 2016 Standards Supplement. The following team conducted the audit: Ernest Umunna, Chairperson and Brenda Boyd, Team Member. This is an initial audit because the facility is using a new accreditation manual for the PB, HCALDF. The IHSC-EPC was previously accredited using the PB, HCACI manual in 2015. Other accreditations include National Commission on Correctional Health Care (NCCHC) - 12/2016 and Performance Based National Detention Standards (PBNDS) - 12/2018 (ICE).

B. Facility Demographics

Rated Capacity: 840 (Males-616 and Females-224)
Actual Population: 769 (Males-540 and Females-229) as of 11/05/2018
Average Daily Population for the last 12 months: 749
Average Length of Stay: 0 months 90 days
Security/Custody Level/Clothing designation:

- Medium-High-(Females: Orange-11 and Males: Orange-35)
- Medium-Low-(Females: Orange-78 and Males: Orange-177)
- Low-(Females: Blue-133 and Males: Blue-288)
- High-(Females: Red-7 and Males: Red-38)
- SEG-(Female: 0 and Males: 2)

Age Range of Detainees: 18-80 years old
Gender: Male/Female

(b)(7)(E)

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(b)(7)(E)

C. Facility Description

The El Paso Processing Center (EPC) is part of the Department of Homeland Security, Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations and the El Paso Field Office. It is the holding and processing facility for detainees while they undergo administrative proceedings regarding their right to remain in the United States.

The facility is located in East-Central El Paso, near the El Paso International Airport. The facility shares the land it sits on with the U.S. Border Patrol Sector Headquarter at 8915 Montana Avenue, El Paso, Texas 79925. The EPC's original buildings were constructed in 1968.

Modernized processing (intake/release), dining, medical, and laundry facilities were constructed between 1996 and 1998. The Executive Office for Immigration Review (EOIR) was also constructed between 1996 and 1998 and sits adjacent to the EPC. The building consists of court rooms, offices and a secured visitation/interview area. The EPC is situated on a combined 25 acre parcel of land alongside a Customs and Border Protection/Border Patrol facility and occupies the northern portion of the property. It is located on an approximately 16 acre site.

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Level II detainees (Orange uniforms) normally have a criminal history and Level III detainees (Red uniforms) mostly have aggravated felonies as part of their criminal history. Males and females are housed separately. Level I detainees are housed separately but may be housed with Level II detainees. Level II detainees may also be housed with Level III detainees. Level I and Level III detainees are never housed together.

There are eight separate housing buildings of various sizes and construction. Buildings 7 and 8 are the newest and have four individual "pods" or housing units, each with a capacity of 64. (b)(7)(E) (b)(7)(E) (b)(7)(E) (b)(7)(E) Each pod contains its own showers, toilets, washbasins, and water fountains, dayrooms with equipment, telephones, vending machines and washer / dryer machines for specific laundry needs.

Buildings 1 through 4 are located on the western end of the compound and are commonly referred to as "Barracks". Each of these barracks has a capacity of 64 and contains all necessary showers, toilets, washbasins, drinking fountains, dayrooms and equipment, telephones, vending machines, and washer/dryer machines. Buildings five and six, centrally located on the compound, can house 32 and 48 detainees respectively. They are also commonly referred to as "Barracks". These barracks currently house "temporary" detainees that are awaiting next day or impending transfer to another facility or to Albuquerque to be housed there as part of the agency's expedited removal program.

The mission of the El Paso Processing Center is to "provide a facility that is safe, clean, and sanitary for detainees waiting the processing of their administrative hearing and or immigration cases". The ICE Health Services Corps (IHSC) is responsible for all of the Health Care Services at the El Paso Processing Center and operates a full service clinic in a separate building located in the southeast section of the facility. The clinic includes an infirmary of six beds in an open dorm type setting and three individual negative pressure capable isolation cells. There is a pharmacy and three provider exam rooms. There is a sick call building across the medical clinic with an exam table. There is a nursing station with three stations for nursing interviews and a room near the entrance way with a pill cart that is utilized for pill call. The rest of the building includes storage, a room for drawing labs, an x - ray (digital) room, offices and a small conference room. A separate modular building houses the offices of the Mental Health Providers, the Nursing Manager, the Lead Medical Records Technician and the Administrative Assistant.

Vision

To be the best health care delivery system in detention and correctional health care.

Mission

Provide the safe delivery of high - quality care to those in ICE custody.

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Core Values

- Integrity: We consistently conduct business and deliver goods and services openly, honestly, and to the best of our ability.
- Commitment: We are committed to providing quality, cost - effective health care in collaboration and partnership with both federal and non-federal partners.
- Accountability: We are responsible for our personal and organizational decisions, actions, and results. We are good stewards of government funds and resources.
- Service: We strive to satisfy and meet the needs of the organization and stakeholders in support of immigration law enforcement.
- Excellence: We provide services and mission support utilizing highly qualified health care professionals in order to work towards achieving optimal outcomes.

(b)(7)(E) Units 1 to 7 house the male detainees. Units 1 to 4 have the capacity of 74, Unit 5 has the capacity 20, Unit 6 has the capacity of 44 and unit 7A-7D has the capacity of 64 each. Units 8A, 8B, 8C and 8D houses the female detainees and each has the capacity of 56. There are available Special Management Unit A (SMU-A) for admin. Males/females with capacity of 14, Special Management Unit D (SMU-D) for disciplinary males/females with capacity of eight and a Medical Housing Unit (MHU) for medical males/females with the capacity of nine. Male and female detainees are never housed together or allowed to comingle. (b)(7)(E)

(b)(7)(E)

National Commission on Correctional Health Care (NCCHC), 12/2016 and Performance Based National Detention Standards (PBNDS), 12/2018 (ICE) accredits the facility.

D. Pre-Audit Meeting

On Sunday, November 4, 2018 the members of the IHSC and ICE audit team were transported from the El Paso International Airport, El Paso, in El Paso County, Texas, to the Hawthorn Suites by Wyndham El Paso by the ICE Deportation Officer (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) The distance from the airport to the hotel was approximately 0.7 miles, 14 minutes.

The audit team members (IHSC and ICE) attended an "ice breaker" dinner at the Cattle Baron restaurant that Sunday approximately from 5:00 p.m. to 6:30 p.m. that evening with the facility representatives from the ICE and IHSC.

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General conversation followed as the team member and the facility staff became acquainted, and general audit goals and procedures for the audit were discussed. The audit team met at the hotel on that evening to discuss the information provided by the Association staff and the officials from the El Paso Processing Center (IHSC). The chairperson divided the standards into the following groups: Standards #4-ALDF-2A-45 to 4C-40 to (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Chairperson and Standards #4-ALDF-4D-02 to 4D-27 to (b)(6); (b)(7)(C) Team Member.

E. The Audit Process

1. Transportation

On Monday, November 5, 2018, the audit team was picked up from the hotel by the ICE Deportation Officer (b)(6); (b)(7)(C) at 7:35 a.m. and arriving EDC at 7:45 a.m. The team followed the EDC's security procedures and was escorted into the facility by (b)(6); (b)(7)(C) Snr. Detention and Deportation Officer (SDDO), (b)(6); (b)(7)(C) GPS ACA Compliance Supervisor and Lt. (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) IHSC Compliance Officer.

2. Entrance Interview

At 7:59 a.m., the audit team proceeded with the formal entrance meeting at the facility (ICE) multipurpose room. It was a joint entrance interview with the ICE audit team. The team discussed the logistics of the tour and of conducting the two separate audits. Staffs were asked about any problem areas of which the teams should be aware. The staffs were advised that the audit team would meet with them each evening prior to their departure from the facility to discuss the progress of the audit up to that point, and any problems that were encountered, and the audit team will attempt to review all the mandatory standards on the first day. Escorts were requested to accompany the auditors on the tour and subsequent visits to departments, and to note the number of detainees and the names and titles of employees with whom the auditors spoke. The staffs were asked if any detainee or employee had requested to speak with the auditors.

No requests had been made. The audit chairperson expressed the team's appreciation and the appreciation of the ACA for the opportunity to be involved with the audits in its initial accreditation process, and emphasized the goals of the accreditation, which are to improve the efficiency and effectiveness of correctional systems throughout the United States. The chairperson explained the reason for the initial vs. reaccreditation audit.

The audit teams were aware that the staffs had worked long and hard in preparation for this event, and accordingly the teams would endeavor to provide a fair, equitable and thorough audit as possible while holding facility accountable to high standards.

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The team members would visit as many departments and areas as possible relating to the audit and meet and speak with as many staffs and detainees as possible in the time available, while at the same time strive to be as non-intrusive as possible.

It was requested that when audit team members paused to speak with detainees, that staffs step away so that the conversation may remain private and the team would like to observe the practice in any medical emergency. The audit team reemphasized that the purpose of the audit is to be helpful and to assist the facility in achieving its initial - accreditation. The entrance meeting lasted until 8:25 a.m. The following persons were in attendance:

(b)(6); (b)(7)(C)	Officer in Charge (ICE OIC) Assistant Officer in Charge (ICE AOIC) Supervisory Detention and Deportation Officer (ICE SDDO) Supervisory Detention and Deportation Officer (ICE SDDO) Maintenance Supervisor (ICE) Global Precision Systems (GPS)/ASSET Security Project Manager GPS/ASSET Assistant Project Manager GPS Quality Assurance/Quality Control Manager GPS Quality Assurance/Quality Control Officer GPS Food Service Manager ASSET 1st Shift Captain GPS Contract Detention Operations Supervisor GPS Contract Detention Operations Supervisor GPS ACA Compliance Supervisor SDDO, DHS/ICE/ERO/EPC GPS ACA Compliance Supervisor Lieutenant Commander Health Services Administrator Lieutenant Medical Compliance Officer

3. Facility Tour

The audit team toured the medical area and other areas relating to the IHSC audit from 8:30 a.m. to 11:35 a.m. ACA audit notices were posted throughout the facility (English and Spanish).

Staff and detainees were aware that an audit was taking place. Most of the facility was toured jointly (ICE / IHSC auditors). The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

(b)(6); (b)(7)(C)	Lieutenant Commander Health Services Administrator Lieutenant Medical Compliance Officer

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(b)(6); (b)(7)(C)	GPS ACA Compliance Supervisor SDDO, DHS/ICE/ERO/EPC GPS ACA Compliance Supervisor Supervisory Detention and Deportation Officer (ICE SDDO) Supervisory Detention and Deportation Officer (ICE SDDO) Maintenance Supervisor (ICE) Global Precision Systems (GPS)/ASSET Security Project Manager GPS/ASSET Assistant Project Manager GPS Quality Assurance/Quality Control Manager GPS Quality Assurance/Quality Control Officer ASSET 1st Shift Captain GPS Contract Detention Operations Supervisor GPS Contract Detention Operations Supervisor

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security:

(b)(7)(E)

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(b)(7)(E)

Environmental conditions:

Temperature, airflow and lighting are kept at comfortable levels throughout medical areas and the facility. The noise levels are low. The audit team did not observe any shouting, banging on doors, offensive smell or smell of paint. The audit team interviewed several detainees on overall environmental welfare and condition inside the facility, and they were complimentary. There is no evidence of pest or rodent infestation or complaint. All areas of the facility are clean and well maintained. The housing units were quiet and there appeared to be a very low level of tension in the units.

Sanitation:

Sanitation is provided using detainees and staff assistance. The entire building was very clean as was the rest of the facility. The medical areas were remarkably clean with all cleaning materials kept in clean rooms with no caustic or toxic chemicals present. Cleaning solutions were all distributed from a central location where they are properly diluted before distribution. The master SDS of all chemicals are kept in the main clinic and updated accordingly. Stericycle is contracted to pick up medical waste on a regular schedule. Sanitation of administrative areas is contracted through the Mavagi Enterprise, Inc., San Antonio, Texas, and trained on biohazard cleaning.

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Eyewash stations are located in all areas of the facility, including medical and checked for expiration and replenishment. Hand washing rules are posted in all the bathrooms.

Fire Safety:

Facility is equipped with proper sprinkler systems and working fire alarm systems. Fire extinguishers were located throughout and had been properly checked.

Fire drills had been conducted regularly and all inspections including fire extinguisher were up-to-date. Fire inspections provided by El Paso Fire department. Hazardous materials were stored properly in designated and appropriate storage areas. Safety Data Sheets comprising of all chemicals in the facility are present. Control, accountability, and inventory were maintained. Flame resistant furnishings and waste containers were observed throughout the facility. The facility is a non-smoking facility; however, there are designated smoking areas outside the secure perimeter.

Food Service:

Food Service is contracted through the Global Precision Systems (GPS). Contract was established in 12/2016. The food service area is clean. The area is inspected weekly by food service staff, monthly by the safety officer and annually be the health department. A five weeks menu cycle, approved annually by a Registered Dietitian, is utilized and based on three hot meals per day. A diet for health, hyper calorie diet, renal diet, vegetarian and texture modifications are available. There is one dining hall of 230 capacity.

The audit team observed trays and sampled one lunch meal of turkey sandwich, pack of sunflower seeds, two - slices of white bread, hot vegetable soup with meatballs, salad with 100 dressing, salt and pepper and a choice of drink or water on the first day of the audit. The meal was nutritionally adequate, palatable and temperature tested. There are no pork products served. Medical diets are provided by the food service department upon receipt of written instructions from the facility Clinical Director. Meals samples are kept for 72 hours. At the time of the audit, there were 22 medical diets. These diet orders contain both start and stops dates. These may be ordered anywhere from one day to length of stay. Pregnant detainees receive special diets and extra snacks. Medical evaluations and screenings are done on detainee workers which monitored personal hygiene, cuts/sores, burns, runny nose, nail condition and cold/flu symptoms. Detainees are not allowed to prepare meals. There is one walk-in freezer, two walk-in coolers and one dry storage. Refrigerators, freezers and the dry storage area are clean, orderly and clutter - free, and temperatures are in the appropriate ranges. The dishwasher was in proper working order, and documentation reflected temperatures in the appropriate range. The cost per meal is $1.29.

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Medical Care:

Medical services at the El Paso Processing Center IHSC (EPC-IHSC) are contracted through the STG International (STGi) on August 20, 2018. They also utilize Public Health Service (PHS), Government Service/ICE and as needed contracted staffing.

They provide medical, mental health and dental services. EDC medical receives transfers and in - transit, border patrol and intra and inter system transfer detainees and some with the history of high-risk behaviors, compounded by lack of medical care and or mental health treatment, and are more likely to have chronic illnesses and infectious diseases.

EPC-IHSC is an intake/releasing facility. The facility has a responsible physician (MD) and a Health Services Administrator (HSA). The working relationship between medical, mental health, program, dental and security are very remarkable. Medical staffs are well trained and caring professionals. The audit team interviewed several detainees, including the pregnant females, the youngest and oldest male and female, and they were complimentary of medical services. Telemedicine is practiced at the EPC-IHSC. The audit team observed an intake process from the border patrol on the first day of the audit, and medical responded accordingly. The medical clinic is extremely small and limited for operational efficiency and services benefiting the detainees.

EPC-IHSC medical operates three shifts: 1st shift from 7:00 a.m. to 3:30 p.m., 2nd shift from 3:00 p.m. to 11:30 p.m. and 3rd shift from 11:00 p.m. to 7:30 a.m. (Sunday-Saturday). The Public Health Service staffs are on call. Schedules allows for shift briefings. (b)(7)(E)

(b)(7)(E)

(b)(7)(E) The audit team observed shift changes on first day of the audit and found the process structured. Medical service is centralized. The EPC-IHSC medical has four examination rooms (one - urgent care and three -regular rooms). Exam rooms have panic buttons. The waiting rooms have access to water, bathrooms, education materials and health pamphlets. New fulltime employees receive in service trainings and OJT trainings. EPC-IHSC medical clinic has the followings:

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- ✓ 5 AEDs (secured and inspected)
- ✓ 2 EKGs (secured and inspected, and read on site)
- ✓ 1 Fixed digital chest x-ray machine
- ✓ 2 Emergency bags (secured, inspected and sealed)
- ✓ 1 Emergency stretcher with straps (secured and inspected)
- ✓ 1 Dedicated emergency medical vehicle-gulf cart
- ✓ 1 Transport gurney (secured and inspected)
- ✓ 1 Secure medication room
- ✓ 1 Medication administration room
- ✓ 3 Medication carts
- ✓ 1 Pill window
- ✓ 3 Refrigerators -Flu, TB Solutions, etc. (1-Pharmacy, 1-Lab and 1-Medline)
- ✓ 1 Refrigerator (Specimen)
- ✓ 7 Portable oxygen cylinders (secured and inspected by Argyle Wielding Supply)
- ✓ 3 Negative pressure rooms (cameras, toilets and sinks, and last professional inspection 8/28/2018)
- ✓ 1 Single room with 6-beds infirmary (call lights, showers, toilets and sinks)
- ✓ 6 Suicide observation rooms (cameras, toilets and sinks)
- ✓ 2 Padded/rubber cells (cameras and toilets)
- ✓ 1 Medical Observation room (camera and toilet)

EPC IHSC is an ADA compliant facility and has an ADA Coordinator. It complies with the Disability Placement Program (DPP) that provides for housing accessible lockers, bunk beds with grabs bars, accessible TTY phones, volume control phones, accessible dayroom tables and accessible path of travel. Building 7 and SEG A are considered ADA units. There are ample supplies of walking sticks, crutches and wheel chairs in the facility.

EPC-IHSC has an agreement with the El Paso Fire Department (0.4 miles, four minutes) for ambulance services in case of medical emergencies. Non - emergent medical transportation is done by facility staff to either a hospital facility or community provider for offsite consultations. The nurses have Basic Life Support (BLS) certifications. Medical maintain basic TTA protocol medicines. The Master SDS is maintained in medical. Officers are trained on first aid, CPR and AED, and are considered first responders. Upon admittance to the EPC - IHSC, detainees receive a detainee handbook to aid in adjustment to detention setting. This documentation contains information regarding medical services, sick call process, grievance procedures and hygiene rules. Other methods are used to inform detainees about MRSA, AIDS, Hepatitis, and the spread of HIV, blood borne pathogens and safety. Medical utilizes language line translation and video orientation. EPC-IHSC medical uses the following hospitals for inpatient hospitalization:

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1. Del Sol Medical Center, El Paso, Texas (ER)
2. Sierra Providence East Medical Center, El Paso, Texas (ER)
3. University Medical Center, El Paso, Texas
4. University Behavioral Health Center, El Paso, Texas (Psychiatric Inpatient)
5. Sierra Medical Center, El Paso, Texas
6. Providence Memorial Hospital, El Paso, Texas

Sick calls are provided seven days a week (Sunday-Saturday) in General Population (GP) and Segregation (SEG).

Detainees sign up for sick calls via call out logs at each housing unit between the hours of 5:30 a.m. and 6: 00 a.m. every day. (b)(5)

(b)(5)

There is a pilot program to install electronic kiosks for sick calls, grievances and etc. Detainees housed in SEG access all medical services via face to face encounters with an RN during daily rounds. The average monthly sick calls are 916. The audit team observed sick call process on the second day of the audit and found the process well organized. Medical requests are triaged daily, and any patient with symptoms is seen within hours. There is no medical copay and no detainee is denied health care service. EPC - IHSC uses detainee electronic medical records. Medical grievance is through the grievance boxes and collected by a grievance coordinator and reviewed by the HSA within seven days. There is no evidence of substantiated medical grievance.

Specialty services/consults are provided through off - site contracted specialists. The turnaround time is routine 30 days, urgent; one to three days and emergency 24 hours and depending medical acuity and specialty. Optometry service is contracted offsite through the Viscount Vision Center, El Paso, Texas and eye glasses through the Correctional Eye Care. There were four pregnant detainees at the time of the audit. All pregnant females are referred to an offsite OB-GYN specialist and are provided pregnancy literatures and snacks. The number of chronic care detainees excluding mental health at the time of the audit was 84. Over 50% of the detainees interviewed showed symptoms of severe skin rashes due to hard water and worsened by cheap body soap and lotion. The audit team recommended a review of facility water hardness and the addition or increase of water softening agent. There is one detainee on hunger strike for three weeks at the time of the audit, but takes liquid diets, and is well attended by medical.

EPC-IHSC has a plan for the management of communicable diseases including education on prevention, diagnosis, treatment and isolation. EPC - IHSC has an infectious disease coordinator. EPC-IHSC has three single bed negative pressure rooms with last inspection date of 8/28/18 by the Air Management Solutions,

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Powder Springs, GA. There is a single room (six beds) infirmary. MRSA precautions are in place. Universal precautions are practiced throughout the facility. There are available first aid and blood borne pathogen kits. There are eye wash stations present in appropriate areas. Hand sanitizers (non-alcohol) dispensers were located throughout medical and other areas. Unit's sanitation and housekeeping are provided by detainees.

Mavagi Enterprise is contracted to clean admin. offices and are trained on biohazard cleaning. An annual TB screening is conducted on all detainees after 12 months. EPC-IHSC offers limited TB sticks, mostly chest x-rays on site.

Medications are stored in medication rooms and secured behind double locks.

A nurse administers medications including diabetic lines three times a day / seven days a week (Sunday-Saturday) and PRN in GP and SEG. SEG is conducted cell side. Diabetics are trained to self-administer. Prior to giving medications, detainee's identification is confirmed, and mouth cavities checked after administration. The audit team observed medication administrations in the GP and SEG on the first day of the audit and found the process organized and timely. All no shows or refusal to medications are documented and or referred. The HSA checks the MARS paper record for missed doses.

The audit team examined the MARS records during the audit and found it current. There are 22 medical diets and 216 diabetics (43 - insulin and 173 - non insulin dependents) at the time of the audit. Some insulin dependent diabetics receive midnight snacks. The average monthly detainees on prescription medications are 1482, and controlled medications are zero. Some medications are crushed per doctor's order. Detainees are provided 30 day script medications upon release.

EPC - (b)(7)(E) (b)(7)(E) EPC-IHSC maintains stock order and patient specific medications, and bulk sharps. Medications are ordered through the McKesson and Diamond pharmacy. The backup pharmacy is the local Walgreen pharmacy. Detainees are allowed keep-on-person (KOP) medications. OTC meds are administered on a dose by dose by nurses. The pharmacy is audited by the Diamond Pharmacist, the Pharmacist and the HSA. A random inventory count on sharps and controlled medications is accurate. The pharmacy has a refrigerator for the storage of insulin, vaccines and ice packs. The audit team found the temperature log and inventory current. Basic medical supplies and materials are obtained through the Two Rivers and AMD medical supplies. The disposal of expired, unused, discontinued, recalled, over stocked medications including prescription, (pills and liquids) and narcotics are arranged through the Reverse Distributor - Pharma logistics. Loose pills are disposed through the use of Stericycle. At the time of the audit there were some medications awaiting disposal. Records are maintained on disposal process.

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(b)(5)

EPC-IHSC medical has a draw only lab. Specimens are collected on site. Blood is spun and sent out for analysis to the LabCorp five days a week, including STAT labs and reports received through fax/phone within 24 to 48 hours. Average monthly detainee lab tests are 225.

Stericycle is contracted to pick up the biohazard and sharps wastes. The audit team checked the specimen refrigerator temperature log and found the records current. Chronic care patients receive annual screening test. Laboratory results are also incorporated into the EMR. Digital radiology is used in the facility with hard copy over - reads scanned into the electronic health record (EMR). There is one fixed wall stand digital chest x-ray machine. One F/T Radiology Technician (STGi) supports the x-ray department.

Radiology services (MRI, Ultrasound, etc.), including STATS are provided through the Del Sol Medical Center, El Paso, TX and XRAD with results received within hours by phone/fax depending on urgency.

One F/T Dentist (PHS), one F/T Registered Dental Assistant (STGi) supports EPC - IHSC dental. Dental services are provided from 6:00 a.m. to 2:30 p.m. (Monday -Friday) four to seven patients a day.

Dental services include basic dentistry, filling, partial, root canal, extraction, oral surgery, cleaning, oral cancer screening and patient education. The detainee's access dental health services through the sick call log process. The audit team reviewed the licenses, registrations, records and random inventory of sharps and instruments and found them accurate. The dental area is clean. Dental instruments and sharps not used at the year of expiration are re -autoclaved and repackaged. Dental spore test is done using the ATTEST. The Dentist has a standing order; dental emergency outside the expertise of the nurse is referred to one of the contracted hospitals. Dental at EPC - IHSC is equipped with one dental bitewing digital x - ray machine, one dental chair and one Panorex digital x - ray machine. The dental wait time is less than one to two days. Urgent requests are seen within 24 hours. The average monthly dental appointment is 71. There is an amalgam separator to the compressor for dental amalgam wastes. Dosimeter reading is through the Luxel + Landauer. Dental chair traps are cleaned twice a week. Dental supplies are through the Two Rivers and AMD and equipment services are through the Henry Schein.

Mental health is supported by (b)(7)(E) (b)(7)(E) (b)(7)(E) They provide services from 7:00 a.m. to 3:30 p.m.

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(Monday-Friday). Detainees access mental health services via the sick call log process. Staffs can refer services. There are approximately 111 detainees seen monthly. All suicide ideations are referred to mental health and monitored and are observed 1:1. Mental health utilizes the six single - bed isolation and two padded/rubber rooms. There are available suicide smocks and blankets.

Tele-psychiatry is practiced at EPC-IHSC. EPC-IHSC maintains zero tolerance for sexual abuse and harassment. Detainees are provided information on enhanced victim services and rape crisis hotline. Rounds are done weekly and are evaluated every 30/60/90 days depending on needs. Program services include crisis intervention, individual and group counseling and medication management. EPC-IHSC has no therapeutic community program and does not house severely developmentally and disabled detainees. EPC-IHSC utilizes the University Behavioral Health Center, El Paso, Texas for psychiatric inpatient hospitalization.

There were approximately 280 detainees on psychotropic medication at the time of the audit. EPC-IHSC does not perform detoxification from alcohol, opiates hypnotics, other stimulants and sedative hypnotic drugs.

Chemical dependency treatment program is not provided. Detainees needing services are referred offsite. EPC - IHSC utilizes medical and psychiatric restraints.

Recreation:

Each housing unit has its own recreation yard at EPC. There are two Recreations Specialists who coordinate recreation activities for the detainee population. There are indoor and outdoor recreation areas. The recreation specialists also deliver detainees mails and assist in supplying the library services.

All are allowed at least two hours per day of outside activity. There are also indoor activity rooms for more sedentary activities, including board games, foosball, and television viewing. Segregation detainees are also allowed outside recreation at least once per day in a covered spacious yard. Only one segregated detainee is allowed at a time.

Religious Programming:

Religious Services staff consists of three members. There is a Chaplain and two assistants along with fifteen volunteers currently representing five religious denominations and two spiritual counselors. The Office of the Chaplain maintains open communication with the diverse religious leaders in the community to provide spiritual support on an as needed basis to allow the free exercise of the diverse religious beliefs and practices of the detainees. Many religious items such as beads, literature, prayer rugs and prayer cards are donated by the local religious community and provided to the detainees.

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The religious services staff maintains an active role within the facility providing support in special projects such as the opportunity for worship, religious diets, spiritual counseling, spiritual support, and crisis intervention.

Work Programs:

The facility utilizes volunteer detainee labor for various work projects. Detainees are afforded the opportunity to participate in a work program and earn money. Detainees who wish to participate in the work program will be paid one dollar a day and not be permitted to work in excess of eight hours daily, 40 hours weekly.

There is a color uniforms to distinguish male (white) and female worker (brown). Some examples of work assignments available for the detainees include kitchen, library aide, laundry, janitorial, barbershop, and grounds keeping crew, paint/wax and recreation specialist workers.

Academic and Vocational Education:

The ICE does not provide special services such as education, vocation. The primary purposes of detention are to guarantee aliens' presence in immigration court hearings and to ensure their removal from the U.S. when removal is ordered. ICE does not provide educational or vocational programs except for minors under limited conditions.

Social Services:

The facility utilizes both qualified staff members and community volunteers to deliver services such as drug and alcohol dependency counseling and mental health treatment. Services are available on an as - needed basis, and providers are contacted on an on - call basis when not on duty at the facility.

Visitation:

The EPC allows detainees to receive visits from family, friends and legal representatives. Visits are permitted during set hours on weekdays, weekends, and holidays. Interviews with attorneys are allowed seven days a week from 7:00 a.m. to 10:00 p.m. Non - contact visits are permitted during set hours and a visitation schedule is posted in all housing units. The visitation area is located in the Executive Office of Immigration Review Building (EOIR) and is managed by contract security staffs. Storage lockers are available for visitor's personal belongings. Special and contact visits are afforded to detainees by submitting a request and having it approved by a Detention Operations Supervisor. Consular officials may meet with their detained nationals at any time. Clergy may visit detainees at any time but must make prior arrangements with the Chaplain's Office.

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Library Services:

The EPC has a library available to all detainees for legal research and recreational reading. Library operations are coordinated by the facility Recreation Specialists and are staffed by contract security officers. Detainee library aides employed through the volunteer work program assist other detainees in the library. Library schedule is coordinated according to gender and classification status. There are 14 computers workstations, two printers, and I copier available to detainees who wish to utilize the library.

Laundry:

The Laundry operates seven commercial washers with an automatic detergent feed and seven commercial dryers. The laundry operates from six to 11 hours daily and is supervised by contract security staff and operated by volunteer detainee workers. Detainee uniforms are exchanged three times a week on Mondays, Wednesdays, and Saturdays. Sheets and towels are exchanged twice a week.

Blankets are exchanged once a week. Seasonal items issued to detainees are sweater and jackets. Upon admission, detainees receive one blanket, two sheets, one towel, two uniforms, one pair of shoes, one pair of sandals, two pair of socks, two pair of underwear, and two t - shirts. Lint traps are cleaned daily.

F. Examination of Records

Following the facility tour, the team proceeded to a medical private office to review the accreditation paper files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

The facility had no consent decrees, class action lawsuits or adverse judgments in the past year according to records.

2. Significant Incidents/Outcome Measures

The EPC-IHSC only provided Significant Incident Summary and Health Care Outcome from October 2016 to September 2017 in consultation with the ACA and following the transition from the PB,HCACI to PB,HCALDF accreditation process.

Significant Incident Summary

The audit team reviewed the significant incident summary with the health care administrative team as provided. The number of detainees on detainee assaults without weapon was 37 and detainee on staff assault was five.

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While the number is noteworthy and will impact health care services, it was determined that it was within the appropriate range that would be expected for an institution of this size, population, custody level and mission.

Health Care Outcome Measures

The audit team reviewed the health care outcome measures with the health care administrative team as provided.

There were no deaths, no pharmacy dispensing errors, no suicides, no needle sticks and no nursing medication administration errors. There was discussion regarding the following sections on the healthcare outcomes section of the report during the audit period:

1. Standard 4C (5) Number of Hepatitis C positive detainees in the past 12 months was 28, and with the average daily population in the past 12 months of 780. The EPC-IHSC provided statement that facility is an ICE processing facility and receives detainees with existing diagnosis.

2. Standard 4C (6) Number of HIV positive detainees in the past 12 months was 17, and with the average daily population in the past 12 months of 780. The EPC-IHSC provided statement that facility is an ICE processing facility and receives detainees with existing diagnosis from prior lifestyles.

3. Standard 4C (8) Number of detainee's diagnosis with an Axis 1 (excluding sole diagnosis of substance abuse) during the past 12 months was 377, and with the average daily population in the past 12 months of 780. The EPC - IHSC provided statement that the facility is an ICE processing facility. Detainees have adjustment and situation disorders with anxiety.

4. Standard 4C (15) Number of detainee's admission to the infirmary (where available) in the past 12 months was 337, and with the average daily population in the past 12 months of 780. The EPC-IHSC is an ICE processing facility. The number is due to high intakes, medical observations and the need for medical clearance.

The values stated for the measures reflected a very busy facility with high intakes from diverse population, gender, age and nationality with a wide variety of health concerns. The medical auditor concurs with the responses.

3. Departmental Visits

The team revisited the following departments to review conditions relating to departmental policy and operations:

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Department Visited	Person(s) Contacted
Medical	(b)(5); (b)(7)(C)
Medical (cont.)	

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Mental Health

Dental

Medical hallways

Medical waiting area

Intake/Release

Laundry Service

Kitchen

Building 8D

Building 7B

Building 7D

SEG - A

(b)(5); (b)(7)(C)

4. Shifts

a. Day / Evening Shifts

The team was present at the facility from 7:45 a.m. to 6:35 p.m. on the first day of the audit. The team observed the afternoon shift change and briefing and sharps count at 3:00 p.m. The briefing was mutual and participatory.

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The team briefly introduced themselves and discussed the purpose of the audit and matters pertaining to the audit. The team observed medication administration while the rest of the medical staff was busy taking care of the detainees and are pleasant and professional.

LCDR (b)(5); (b)(7)(C) Health Services Administrator (PHS), LCDR (b)(5); (b)(7)(C) Assistant Health Services Administrator (PHS), (b)(5); (b)(7)(C) (b)(5); (b)(7)(C) Contract Coordinator (STGi), (b)(5); (b)(7)(C) Medical Doctor (GS - ICE), (b)(5); (b)(7)(C) Nurse Practitioner (STGi) and 12 other medical staffs were present.

b. Night Shift

The team was present at the facility during the night shift from 7:00 a.m. to 12:21 p.m. on the second day of the audit. The audit team observed the morning shift change and briefing.

Shift briefings are a normal occurrence. The shift supervisors passed on information to the oncoming shift. A familiar and easy rapport was evident among the staff, and information was freely exchanged. LCDR (b)(5); (b)(7)(C) (b)(5); (b)(7)(C) Health Services Administrator (PHS), LCDR (b)(5); (b)(7)(C) Assistant Health Services Administrator (PHS), (b)(5); (b)(7)(C) (b)(5); (b)(7)(C) Medical Doctor (GS-ICE), (b)(5); (b)(7)(C) Nurse Practitioner (STGi) and nine other medical staffs were present.

5. Status of Previously Non-compliant Standards/Plans of Action

This audit was conducted as an initial accreditation audit of the ICE Health Services Corps for the El Paso Processing Center.

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

The audit team interviewed and spoke to approximately 235 detainees (168 - males and 67 - females) individual and in group, including four pregnant females who stated that they generally felt secure at the facility and were treated fairly by staff. Their basic needs were being met and they felt that they were making positive progress towards eventual and successful release. They also felt that their basic medical needs were being met. They have access to sick call process but felt that the 5:30 a.m. to 6:00 a.m. time is very limited and restricted. They were aware of the grievance process.

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Detainee morale appeared to be good and they were cooperative, respectful and were aware of the audit, and participated in the preparation for the audit. Notices of the ACA accreditation process were observed to have been posted at different locations readily available to the detainees.

2. Staff Interviews

The audit team interviewed and spoke to approximately 55 employees and observed them in the performance of their duties. The audit team observed structured medical shift changes briefings. Staffs were polite, cooperative, and conducted themselves in a professional manner. There was a normal working relationship between medical, dental, mental health, programs and security, and communication flowed freely.

Gender and ethnic diversity were good, and morale also appeared to be good. Staff indicated that their training were excellent and are applicable to their positions and job needs.

H. Exit Discussion

The exit interview was held at 12:10 p.m. in the ICE conference room with (b)(5); (b)(7)(C) – Officer in Charge (ICE OIC), (b)(5); (b)(7)(C) Assistant Officer in Charge (ICE AOIC) and LCDR (b)(5); (b)(7)(C) Health Services Administrator (PHS), four - Public Health Services, four - STGi, one - Government Service/ICE employees and the ACA - ICE audit team.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive to maintain their high level of professionalism in the correctional field.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Performance Based Standards for Correctional Health Care in Adult Local Detention Facilities, 4th Edition
Supplement	2016 Standards Supplement
Facility/Program	El Paso Processing Center - IHSC
Audit Dates	November 5-6, 2018
Auditor(s)	(b)(5); (b)(7)(C) Chairperson (b)(5); (b)(7)(C) Member

	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	20	31
Number Not Applicable	0	4
Number Applicable	20	27
Number Non-Compliance	0	0
Number in Compliance	20	27
Percentage (%) of Compliance	100%	100%

- Number of Standards minus Number of Not Applicable equals Number Applicable
- Number Applicable minus Number Non-Compliance equals Number Compliance
- Number Compliance divided by Number Applicable equals Percentage of Compliance

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps (IHSC)
El Paso Processing Center
El Paso, Texas

November 5-6, 2018

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-2C-05

WRITTEN POLICY, PROCEDURE AND PRACTICE PROVIDE THAT MANUAL OR INSTRUMENT OF BODY CAVITIES IS CONDUCTED ONLY WHEN THERE IS REASON TO DO SO AND WHEN AUTHORIZED BY THE FACILITY ADMINISTRATOR OR DESIGNEE. THE INSPECTION IS CONDUCTED IN PRIVATE BY HEALTH CARE PERSONNEL OR CORRECTIONAL PERSONEL TRAINED BY HEALTH CARE PERSONNEL.

FINDINGS:

EPC-IHSC does not conduct inspection of body cavities.

Standard #4-ALDF-4D-04

WHEN INSTITUTIONS DO NOT HAVE QUALIFIED HEALTH CARE STAFF, HEALTH TRAINED PERSONNEL COORDINATE THE HEALTH DELIVERY SERVICES IN THE INSTITUTION UNDER THE JOINT SUPERVISION OF THE RESPONSIBLE HEALTH AUTHORITY AND FACILITY ADMINISTRATOR.

FINDINGS:

EPC-IHSC has a qualified health care staff on duty to coordinate the health delivery services.

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Standard #4-ALDF-4D-10

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A MEMORANDUM OF UNDERSTANDING, WRITTEN AGREEMENT, OR CONTRACT BETWEEN THE FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS THE SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS OR INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

EPC-IHSC does not use students, interns or residents in the delivery of health care.

Standard #4-ALDF-4D-11

UNLESS PROHIBITED BY STATE LAW, INMATES (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE:

- PEER SUPPORT AND EDUCATION
- HOSPICE ACITIVITIES
- ASSISTING IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH ACTVITIES OF DAILY LIVING
- SUICIDE COMPANION OR BUDDY IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF A SUICIDE PREVENTION PLAN
- HANDLING OF DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITATION AND CLEANING WHEN WORKING AS A DENTAL ASSISTANT WHILE IN A TRAINING PROGRAM THAT IS CERTIFIED BY A STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY (INMATES MUST BE UNDER DIRECT SUPERVISION AND IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES)

INMATES ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

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- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMINING ACCESS OF OTHER INMATES TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALTY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

EPC-IHSC does not use detainees to perform familial duties.

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Significant Incident Summary
This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Community Residential Facilities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: El Paso Service Processing Center Reporting Period: Nov. 2017 to Oct. 2018

Incident Type	Months →	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	1	1
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	4	0	0	1	4	3	6	10	2	8	2	4	44
	Offender/ Staff	0	0	0	0	0	0	0	0	0	0	0	7	7
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		0	0	0	0	0	0	0	0	0	0	0	0	0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Name of Facility: EL Paso Service Processing Center Date: December 4, 2018
Number of Months Data Collected: 12 Months (November 2017 to October 2018)

		ALDF Outcome Measure Worksheet		
1B		**Vehicles are maintained and operated in a manner that prevents harm to the community, staff, contractors, volunteers, and inmates.**		
	(1)	Number of vehicle accidents resulting in property damage in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(2)	Number of vehicle accidents resulting in injuries requiring medical treatment for any party in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(3)	Amount dollar of damage from vehicle accidents in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(1)	Number of incidents involving harm in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(2)	Number of incidents in the past 12 months involving harm.	1	
	divided by	The number of admissions in the past 12 months.	20,551	4.8659
	(3)	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the incidents in the past 12 months.	1	
	divided by	The number of admissions in the past 12 months.	20,551	4.8659
	(5)	Number of unauthorized inmate absences from the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(6)	Number of instances of unauthorized access to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
2B		**Physical force is used only in instances of self-protection, protection of the inmate or others, prevention of property damage, or prevention of escape.**		
	(1)	Number of instances in which force was used in the past 12 months.	24	
	divided by	The average daily population in the past 12 months.	751	0.0319
	(2)	Number of instances in which force was used in the past 12 months.	24	
	divided by	The number of admissions in the past 12 months.	20,551	0.0011
	(3)	Number of times that staff use of force were found to have been inappropriate in the past 12 months.	0	
	divided by	The number of instances in which force was used.	24	0

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	(4)	Number of inmate grievances filed alleging inappropriate use of force in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(5)	Number of grievances alleging inappropriate use of force decided in favor of inmate in the past 12 months.	0	
	divided by	The number of grievances alleging inappropriate use of force filed.	0	0
	(6)	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months.	5	
	divided by	The average daily population in the past 12 months.	751	0.0066
2C		**Contraband is minimized. It is detected when present in the facility.**		
	(1)	Number of incidents involving contraband in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(2)	Number of incidents involving contraband in the past 12 months.	1	
	divided by	The number of admissions in the past 12 months.	20,551	4.8659
	(3)	Number of weapons found in the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(4)	Number of controlled substances found in the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(5)	Number of controlled substances found in the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	20,551	0
2D		**Improper access to and use of keys, tools and utensils are minimized.**		
	(1)	Number of incidents involving keys in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(2)	Number of incidents involving tools in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(3)	Number of incidents involving culinary equipment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(4)	Number of incidents involving medical equipment and sharps in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
3A		**Inmates comply with rules and regulations.**		
	(1)	Number of rule violations in the past 12 months.	248	
	divided by	The average daily population in the past 12 months.	751	0.3302
	(2)	Number of assaults—inmate against inmate, inmate against staff in the past 12 months.	44	
	divided by	The average daily population in the past 12 months.	751	0.0585
4A		**Food service provides a nutritionally balanced diet. Food service operations are hygienic and sanitary.**		
	(1)	Number of documented inmate illnesses attributed to food service operations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0

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	(2)	Number of inmate grievances about food service decided in favor of the inmate the past 12 months.	0	
	divided by	The number of inmate grievances about food service in the past 12 months.	2	0
	(3)	Number of violations cited by independent authorities for food service sanitation in the past 12 months.	27	
		Divided by number of violations cited by independent authorities in the past 12 months.	27	1
5A		**Inmates have opportunities to improve themselves while confined.**		
	(1)	Number of inmates who passed GED exams while confined in the past 12 months.	0 N/A	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0 N/A	0 N/A
	(2)	Total number of grade levels advanced by inmates in the past 12 months.	0 N/A	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0 N/A	0 N/A
	(3)	Number of certificates of vocational competency awarded to inmates in the past 12 months.	0 N/A	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0 N/A	0 N/A
5B		**Inmates maintain ties with their families and the community.**		
		NONE		
5C		**The negative impact of confinement is reduced.**		
		NONE		
6A		**Inmates' rights are not violated.**		
	(1)	Total number of inmate grievances in the past 12 months, regarding: (a) access to court; (b) mail or correspondence; (c) sexual harassment; (d) discipline; (e) discrimination; (f) protection from harm.	2	
	divided by	The average daily population in the past 12 months.	751	0.0026
	(2)	Number of inmate grievances (see [a] through [e] above) decided in favor of inmates in the past 12 months.	0	
	divided by	The total number of grievances filed in the past 12 months.	80	0
	(3)	Total number of inmate court suits alleging violation of inmate rights filed against the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(4)	Number of inmate court suits alleging violation of inmate rights decided in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate suits filed in the past 12 months.	0	0
6B		**Inmates are treated fairly.**		
	(1)	Number of inmate grievances regarding discrimination in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(2)	Number of inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate grievances filed regarding discrimination in the past 12 months.	0	0

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	(3)	Number of grievances resolved in favor of inmates in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(4)	Number of grievances resolved in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate grievances filed in the past 12 months.	80	0
	(5)	Number of court malpractice or torte liability cases found in favor of the inmate in the past 12 months.	0	
	divided by	The number of court malpractice or torte liability cases in the past 12 months.	0	0
6C		**Alleged rule violations are handled in a manner that provides inmates with appropriate procedural safeguards.**		
	(1)	Number of disciplinary incidents resolved informally in the past 12 months.	234	
	divided by	The average daily population in the past 12 months.	751	0.3115
	(2)	Number of formal inmate disciplinary decisions that were appealed in the past 12 months.	1	
	divided by	The total number of disciplinary decisions made in the past 12 months.	238	0.0042
	(3)	Number of appealed disciplinary decisions decided in favor of the inmate in the past 12 months.	0	
	divided by	The total number of disciplinary decisions made in the past 12 months.	238	0
	(4)	Number of grievances filed by inmates challenging disciplinary procedures in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	751	0.0013
	(5)	Number of disciplinary-related grievances resolved in favor of the inmate in the past 12 months.	0	
	divided by	The total number of disciplinary-related grievances filed in the past 12 months.	0	0
	(6)	Number of court suits filed against the facility regarding discipline in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(7)	Number of court cases regarding discipline decided against the facility in the past 12 months.	0	
	divided by	The total number of court decisions regarding discipline decided in the past 12 months.	0	0
	(8)	Number of rule violations in the past 12 months.	234	
	divided by	The average daily population in the past 12 months.	751	0.3115
	(9)	Number of inmates terminated from the facility due to rule violations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
6D		**Inmates take responsibility for their actions.**		
	(1)	Number of inmates released in the past 12 months who made regular payments toward their restitution obligations.	0 N/A	
	divided by	The number of inmates who had restitution obligations in the past 12 months.	0 N/A	0 N/A
	(2)	Number of inmates who satisfy their court cost/fines obligations in the past 12 months.	0 N/A	
	divided by	The number of inmates who had court cost/fine	0 N/A	N/A

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		obligations in the past 12 months.		
	(3)	Total amount of restitution paid by inmates in the past 12 months.	0 N/A	
	divided by	The average daily population in the past 12 months.	0 N/A	0 N/A
	(4)	Total number of hours of community service donated by inmates in the past 12 months.	0 N/A	
	divided by	The average daily population in the past 12 months.	0 N/A	N/A
	(5)	Total number of inmates who participated in restitution in the past 12 months.	0 N/A	
	divided by	The total number of inmates housed in the past 12 months.	0 N/A	0 N/A
	(6)	Total number of inmates who participated in community service work in the past 12 months.	0 N/A	
	divided by	The total number of inmates housed in the past 12 months.	20,551	
	(7)	Total number of inmates who participated in victim awareness programs in the past 12 months.	0 N/A	
	divided by	The total number of inmates housed in the past 12 months.	20,551	0 N/A
	(8)	Total amount of restitution paid by inmates in the past 12 months.	0 N/A	
	divided by	The total number of inmates housed in the past 12 months	20,551	0 N/A
	(9)	Total number of hours delivered by inmates who participated in community service work in the past 12 months.	0 N/A	
	divided by	The total number of inmates housed in the past 12 months.	20,551	0 N/A
7A		**The facility operates as a legal entity.**		
		NONE		
7B		**Staff, contractors, and volunteers demonstrate competency in their assigned duties.**		
	(1)	Total number of years of staff members' education as of the end of the last calendar year.	unknown	
	divided by	The number of staff at the end of the last calendar year.	480	unknown
	(2)	Number of staff who left employment for any reason in the past 12 months.	50	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.1041
	(3)	Total number of credit hours in course relevant to their facility responsibilities earned by staff participating in higher education in the past 12 months.	99	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.2062
	(4)	Number of professional development events attended by staff in the past 12 months.	13	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.0041
7C		**Staff, contractors, and volunteers are professional, ethical and accountable.**		
	(1)	Number of incidents in which staff was found to have acted in violation of facility policy in the past 12 months.	89	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.1854
	(2)	Number of staff terminated for conduct violations in the	4	

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		past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.0083
	(3)	Number of inmate grievances attributed to improper staff conducts which were upheld in the past 12 months.	1	
	divided by	The number of inmate grievances alleging improper staff conduct filed in the past 12 months.	4	0.25
	(4)	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months.	1	
	divided by	The average daily population for the past 12 months.	751	0.0013
	(5)	Where staff is tested, the number of staff substance abuse tests failed in the past 12 months.	2	
	divided by	The number of staff substance abuse tests administered in the past 12 months.	170	0.0117
	(6)	Number of staff terminations for violation of drug-free work policy in the past 12 months.	2	
	divided by	The number of staff terminations in the past 12 months.	4	0.5
	(7)	The average number of physicians employed in the past 12 months.	2	
	divided by	The number of physician positions authorized in the past 12 months.	2	1
	(8)	The average number of nurses employed in the past 12 months.	27	
	divided by	The number of nurse positions authorized in the past 12 months.	30	0.9
	(9)	The average number of mid-level health care practitioners employed in the past 12 months.	4	
	divided by	The number of mid-level health care practitioner positions authorized in the past 12 months.	5	0.8
	(10)	The average number of ancillary health care staff employed in the past 12 months.	7	
	divided by	The number of ancillary health care staff positions authorized in the past 12 months.	7	1
7D		**The facility is administered efficiently and responsibly.**		
	(1)	Net amount of budget shortfalls or surplus at the end of the last fiscal year (budget less expenditures).	-4,371,360.07	
	divided by	The budget for the past 12 months.	78,899,535.56	-0.0554041293015692
	(2)	Number of material audit findings by an independent financial auditor at the conclusion of the last audit.	0	
		NONE		
	(3)	Number of grievances filed by inmates regarding their records or property in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	751	0
	(4)	Number of inmate grievances (records/property) decided in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate grievances (records/property) in the past 12 months.	0	0
	(5)	Number of objectives achieved in the past 12 months.	3	
	divided by	The number of objectives for the past 12 months.	3	1
	(6)	Number of program changes made in the past 12 months.	0	
	divided by	The number of program changes recommended in the past 12 months.	0	0
	(7)	Number of problems identified by internal health care	0	

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		review that were corrected in the past 12 months.		
	divided by	The number of problems identified by internal health care review in the past 12 months.	0	0
7E		**Staff are treated fairly.**		
	(1)	Number of grievances filed by staff in the past 12 months.	49	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	480	0.1020
	(2)	Number of staff grievances decided in favor of staff in the past 12 months.	15	
	divided by	The total number of staff grievances in the past 12 months.	15	1
	(3)	Total number of years of staff members' experience in the field as of the end of the last calendar year.	4221	
	divided by	The number of staff at the end of the last calendar year (e.g. average number of years experience).	479	8.8121
	(4)	Number of staff termination or demotion hearings in which the facility decision was upheld in the past 12 months.	4	
	divided by	The number of staff termination or demotion hearings requested in the past 12 months.	4	1
7F		**The facility is a responsible member of the community.**		
	(1)	Total number of hours of volunteer service delivered by members of the community in the past 12 months.	1009	
	divided by	The average daily population of inmates in the past 12 months.	751	1.3435
	(2)	Total number of individual community members who provided voluntary service in the past 12 months.	912	
	divided by	The average daily population of inmates in the past 12 months.	751	1.2143
	(3)	Total number of complaints filed by media regarding access to information in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	751	0
	(4)	Total number of positive statements made by media regarding the facility in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	751	0
	(5)	Total number of complaints from the community in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	751	0
	(6)	Total number of hours of community service work delivered by inmates in the past 12 months.	0 N/A	0 N/A
	divided by	The average daily population of inmates in the past 12 months.	751	0 N/A

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

The Geo Group, Inc.
South Texas ICE Processing Center
Pearsall, Texas

December 9 - 11, 2019

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C) Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The reaccreditation audit of the South Texas ICE Processing Center, Pearsall, Texas, was conducted on December 9-11, 2019, by the following team: (b)(6); (b)(7)(C) Chairperson; (b)(6); (b)(7)(C)

B. Facility Demographics

Rated Capacity: 1,904

Actual Population: 1,385

Average Daily
Population for
the last 12 months: 1,875

Average Length
of Stay: Two months

Security/Custody Level: Minimum offenders (802 Level One males, 286 Level Two males, 88 Level Three Males, 163 Level One females, 34 Level Two females and 12 Level Three females).

Age Range of
Offenders: 18-68

Gender: Female and Male

Full-Time Staff: 417

C. Facility Description

The South Texas ICE Processing Center (STIPC), operated by the GEO Group, is located on 37 acres in Pearsall, Texas, which is approximately 50 miles from the San Antonio International Airport. Pursuant to a contract with Department of Homeland Security (DHS) and Immigrations Customs Enforcement (ICE), STIPC provides civil detention for detainees who are in the United States illegally or who are seeking asylum.

The facility, consisting of a 242,195 square foot building, houses up to 1,904 male and female, minimum-security detainees within three classification levels. With the exception of a two-story Special Management Unit, the entire complex is one story. The facility design is made up of a quarter mile main hallway with housing units and departments located off each side of the hallway. The Special Management Unit is located at one end of the main hallway and consists of RHU A (36 single cells), RHU B and C (36 double cells in each) and FF (one single cell and nine double cells for females).

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The other 25 dormitory-style housing units are located along the main hallway and consist of either 60 or 100 beds. The dormitories have an open design (b)(7)(E) (b)(7)(E) The beds are located on each side of the dorm with dayroom seating located in the middle. The wall opposite the entry door is full glass that opens into an outside enclosed recreation yard.

In the center of the main hall, is the Administrative Area, Master Control, Medical Unit, Asylum Interview Area, Immigration Court Rooms, Food Services, Maintenance, Intake and the Property Room.

In August of 2012, the size of STIPC was expanded by 3,815 square feet. The expansion, adjacent to the existing office area, provided for an ICE training room, six new offices, nine work stations, a copy room, supply room and restrooms. The facility complex has offices for (b)(7)(E) staff members. A Judicial Area with four courtrooms also exists. The renovations also included a 22,000 square foot recreation yard with adequate space for a full size soccer field, shade pavilions and picnic tables. (b)(7)(E) (b)(7)(E) A new outdoor recreation yard was added adjacent to the existing Special Management Unit. Additionally, a major expansion of parking for staff and visitors was included in the renovations.

In March 2016, the contract between GEO Group and ICE and DHS was amended to provide housing for 130 female detainees. There are two housing units for females (100 bed dormitory and 17 bed dormitory).

DHS and ICE monitor the facility by means of periodic audits and inspections. GEO Group also monitors the facility through corporate audits and its Quality Assurance Program. ICE often uses the complex for training of offsite ICE staff and contract employees with regard to facility operations.

STIPC's mission statement states as follows: "The South Texas ICE Processing Center is a privately owned and operated detention facility for profit. The facilities primary contractual responsibility is to provide security and transportation services to the Department of Homeland Security's Immigration and Custom's Enforcement.

It is the mission of the South Texas ICE Processing Center to provide the highest level of service to our clients, our primary objective being to ensure the safety of the community, staff and those entrusted into our custody. This mission is accomplished through well-selected, trained, professional staff that exhibits dedication, integrity, responsibility, ethical conduct and pride in their daily lives.

As an employee of the South Texas ICE Processing Center, you are the most valuable and important resource of this agency. Neither this agency nor this facility can perform their vital public mission for the citizens of Texas without the professional and dedicated service of our employees.

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D. Pre-Audit Meeting

The team met on December 8, 2019, in Pearsall, Texas, to discuss the information provided by the Association staff and the officials from DCC.

The chairperson divided standards into the following groups:

Standards #1B-01 to 1B-06
#1C-01 TO 1C-15
#2A-01 to 2D-03
#3A-01 to 3A-02
#4A-01 to 4A-16
#4B-01 to 4B-09: (b)(6); (b)(7)(C) Chairperson

Standards #5C-01 to 5C-26
#6A-01 to 6D-01
#7A-01 to 7G-01: (b)(6); (b)(7)(C) Member

Standards #1A-01 to 1A-23
#4C-01 to 4C-41
#4D-01 to 4D-28
#5A-01 to 5A-10
#5B-01 to 5B-18 (b)(6); (b)(7)(C) Member

E. The Audit Process

1. Transportation

The team was escorted to the facility by (b)(6); (b)(7)(C) Director of Contract Compliance, Central Region.

2. Entrance Interview

The audit team was taken to the facility conference room, where they met with (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Facility Administrator. The team expressed the appreciation of the Association for the opportunity to be involved with STIPC in the accreditation process. After being asked whether there were any issues that the audit team needed to be aware of that could affect the audit, Facility Administrator (b)(6); (b)(7)(C) indicated that there was nothing of which he was aware. After further preliminary issues were discussed, the chairperson informed Facility Administrator (b)(6); (b)(7)(C) that the audit team would try to be as non-intrusive possible while performing a thorough and fair audit.

The formal entry meeting was held in the conference room.

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The following persons were in attendance:

(b)(6); (b)(7)(C)

It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time. All of the attendees introduced themselves and stated their positions of employment. The members of the audit team were introduced and each one was allowed to give a brief biography. The chairperson expressed appreciation for the opportunity to perform the reaccreditation audit of STIPC and stated that the audit would be thorough and fair.

3. Facility Tour

The team toured the entire complex from 9:00 a.m. to 12:30 p.m. The tour was divided into in three separate groups. The following persons accompanied the team on the tour and responded to the team's questions concerning the operations of the complex:

(b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

Facility notices were posted throughout the facility.

4. Conditions of Confinement/Quality of Life

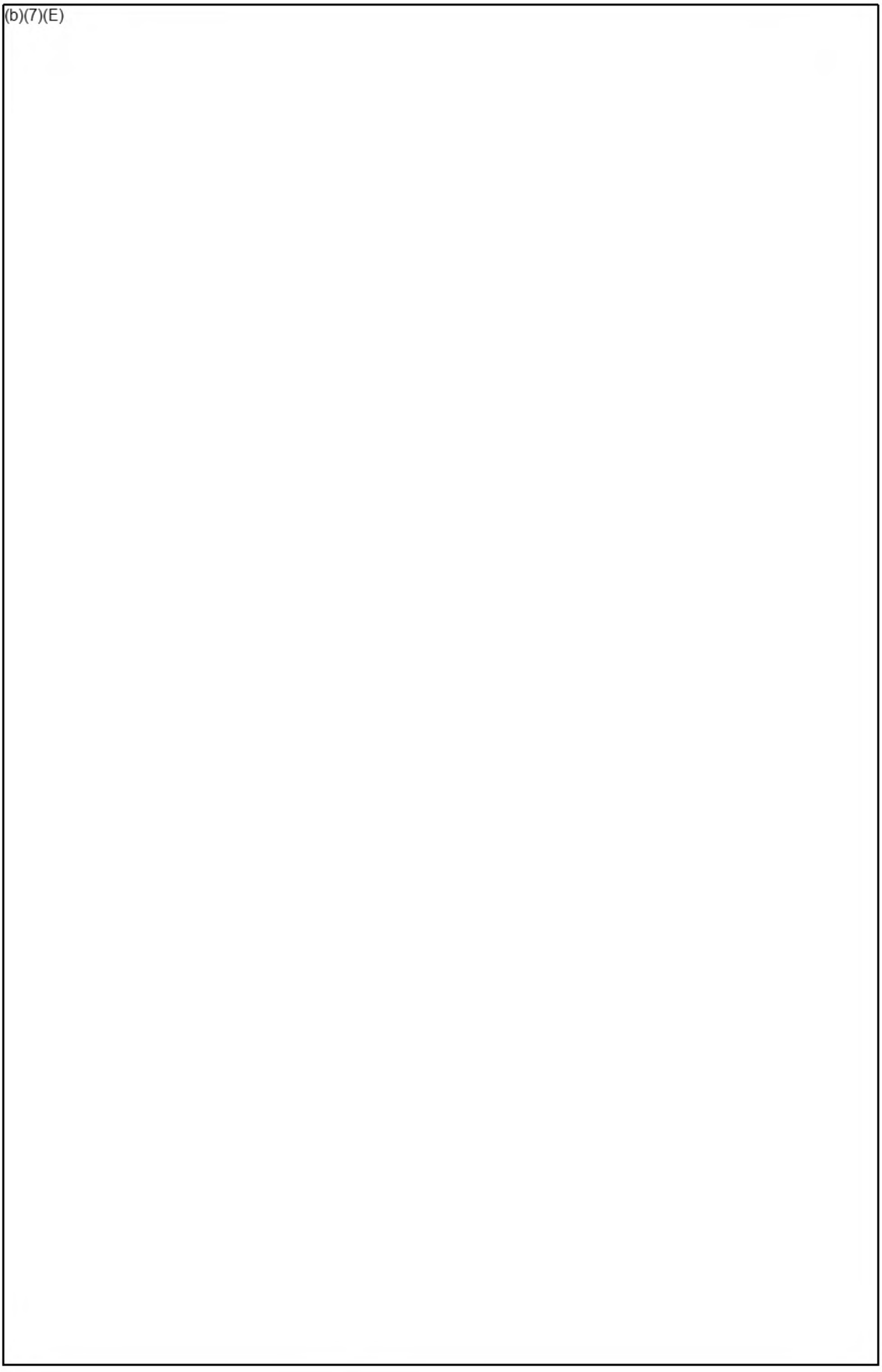
During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security:

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AMERICAN OVERSIGHT

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Environmental Conditions:

STICP's Maintenance Department, which is made up of a Facility Maintenance Manager, seven Maintenance Techs (skills in electrical, plumbing, carpentry, HVAC and general maintenance) and one accounting clerk, is responsible for the upkeep, construction and repairs of all facility equipment and structures. There are no detainee workers.

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Preventive maintenance schedules for the facility, to forestall structural problems, are maintained through a computerized system (developed by GEO) called the Facility Dude. As deficiencies are reported (by email, phone, verbally or electronically), work orders are prepared through Facility Dude and assigned to the appropriate craftsman who will then correct the deficiency pursuant to four priority designations: emergency (repaired immediately), high (repaired within two days), medium (repaired within seven days) or low (repaired within a reasonable time). Work orders are documented and tracked through Facility Dude. A member of the audit team was provided a demonstration of Facility Dude and was very impressed by its functionality. When maintenance jobs are beyond that which the facility's maintenance staff can address, it seeks assistance from private contractors. A system exists to monitor tools that are brought onto the grounds of the complex by private contractors.

STIPC's complex appears to be well maintained. Light, noise and airflow conditions have been tested by a qualified environmental expert and all fall within approved ranges. The facility is completely air-conditioned. The temperatures inside the complex during the time of the audit were very comfortable. Offender living areas have a sufficient number of windows providing them access to natural light. Furnishings throughout the facility, including bedding in the living areas, are in good condition and properly fire rated. The grounds of the complex, both inside and outside the perimeter, were in excellent condition.

The facility has one 500KW emergency generator, which is capable of providing the essential power needed at the complex during emergencies. The generator is inspected, and load tested weekly (45 minutes) and monthly (60 minutes). The generator is load bank tested annually. Preventive maintenance on the generator is performed quarterly by Clifford Powers. The generator was last serviced on 9-6-19. Servicing, load testing and inspecting were all documented.

The dayroom areas within the housing units have tables with attached benches for seating at each table. The dayroom area provides televisions, telephones, and four microwaves for the detainees. There is ample seating in the dayrooms to accommodate the detainees. There is a monitor that allows detainees to engage in video visitation. Detainees are allowed to check out computer tablets for up to two hours of use. Detainees can recheck a computer tablet for another two hours of use if one is available upon checking in the tablet. Recreation within the housing unit includes cards and games, such as UNO, checkers, chess, Connect4, Scrabble, SkipBo, Chinese checkers, dominos and monopoly.

The facility does not meet the standards (4-ALDF-4B-08 and 4-ALDF-4B-09) regarding ratios for showers, toilets, and washbasins. The audit team did not observe any waiting lines for the toilets, showers, or washbasins. The audit team did not receive any complaints from detainees with regard to difficulty in accessing showers, toilets or washbasins.

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The facility is tobacco-free. Absolutely no tobacco products are allowed on the grounds of the facility, thereby enhancing the overall environment and adding to the positive quality of life associated with a concern for detainee health and wellbeing.

Sanitation:

The facility has a detailed Housekeeping Services Plan, which it uses as a standard for maintaining its sanitation level. Detainees perform all of the cleaning in the living areas and hallways of the facility seven days a week under the supervision of members of staff. Detainees receive instruction and training with regard to the use of cleaning agents, equipment and sanitation expectations. The complex utilizes a Versa-Fill pre-diluted cleaning supply system that allows for a controlled, inventoried, and cost effective delivery of the supplies necessary for maintaining a clean and sanitary environment. The cleaning chemicals are diluted prior to distribution in plastic labeled containers from the chemical storage area on a weekly basis. Chemicals throughout the complex are securely stored. Inventories were checked and the system appears to be well managed. The supply system was adequately demonstrated for the audit team. Personal protective equipment is available for use. SDSs were present and readily available where all chemical and caustics were stored.

Shower areas and bathrooms were clean and free of odor, soap residue and mold or mildew. Living, common and administrative areas were clean. There was no accumulation of trash inside or outside of the facility. No areas of the facility had bad smells. The audit team did not observe any areas of the facility that were badly in need of paint. It was apparent during the tour of the facility that good sanitation practices are practiced. The most recent health inspection report was dated 8-22-19 with a finding of, "There is no deficiency/violation cited or noted." The audit team reviewed Weekly Fire and Safety Inspection forms. The audit team did not witness the presence or signs of insects or rodents. Detainees and members of staff take justifiable pride in their efforts to keep the facility clean.

Fire Safety:

The complex is protected from the danger of fire and smoke by the IFP-1000 fire alarm system (tested annually and last serviced on 9-17-19). Protection from fire and smoke is achieved through this system by smoke detectors, heat detectors, duct detectors, pull stations and horns/strobes. The fire alarm annunciator panel is located in Master Control, which was functioning at the time of the audit. A smoke detection panel is also present in Master Control. Additional suppression and fire safety equipment includes sprinklers (tested annually and last serviced on 9-17-19), 71 fire extinguishers (fully charged with current inspections) and eight fire hydrants (tested quarterly and last serviced 11-21-19). The kitchens utilize the Ansul hood wet chemical fire suppression systems (tested semi-annually and last serviced on 3-1-19).

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Fire drills are conducted quarterly and during the audit period were almost exclusively simulated. A member of the audit team was informed that in the future all fire drills would include evacuations. The most recent fire drill was carried out 11-28-19, which was documented. A member of the audit team reviewed numerous Fire Drill Reports, which are very detailed (19 questions of evaluation). Detainees who had participated in fire drills that included evacuations were able to describe the process. Exit signs and emergency lighting were operable. Evacuation plans were current, prominently displayed and appropriately approved. Weekly and monthly inspections are conducted and documented. The most recent annual fire alarm inspection was conducted on 9-17-19, which resulted in a finding of an inoperable duct detector. On 11-25-19, a Corrected Impairment form was filed verifying that the duct detector had been repaired. The most recent annual sprinkler system inspection was conducted on 9-17-19, which resulted in a finding of expired water gauges. On 10-18-19, a response to the finding was filed, indicating that the water gauges had been repaired. The most recent annual fire inspection was conducted by the State Fire Marshall on 3-19-19, wherein no deficiencies were noted. The Frio County Fire Department (five miles away) provides emergency fire response and service protection.

Food Service:

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(b)(7)(E) The detainees receive medical clearances and are physically screened by medical prior to assignment in the kitchen. The facility provides its own food service and follows a five-week menu cycle, which is reviewed and approved by a licensed dietician. Menus are designed to provide approximately 3,200 calories per day. The cost per meal per offender ranges from .87 to .90 cents per meal. Special diets for medical and religious reasons were analyzed, approved and documented. At the time of the audit 37 medical meals and 11 religious meals were being prepared. All GEO food services employees are ServSafe certified. Detainees do not reside long enough at the facility to engage in the ServSafe program.

There is one kitchen in the facility, which is spacious and well appointed. The refrigerator, freezer and dry storage areas were clean, orderly and maintained at proper temperatures. A review of the temperature logs indicated that temperatures were checked on a regular basis. Food containers were stored off the floor and at appropriate distances from walls and ceilings. The food preparation areas were clean and orderly. The range guards were clean and free of grease. During the time of the audit, food temperatures on the serving line were checked. The food was found to be at appropriate temperatures. Food temperatures were documented. All members of the staff and offender population were properly attired, wore head coverings and observed appropriate sanitation practices.

AMERICAN OVERSIGHT

A member of the audit team reviewed Opening and Closing Checklists, wherein daily detainee and staff health checks were documented.

Shadow boards, inventory logs, issue/return logs and identification chits are maintained with regard to the storage and use of kitchen tools and utensils. Tools and utensils are classified as "Restrictive" (shadowed in red) and "Non-Restrictive" (shadowed in black), when is use, restrictive tools are tethered. All the tools and utensils were securely stored in a locked cage. Tools and utensils are checked out through the use of chits and logs. Through specific inquiry, the audit team was able to verify the inventory and location of tools and utensils. Inventory of all tools and utensils are cleared at the beginning and end of every shift.

There is no detainee dining room. Detainees have their food delivered to their housing areas in insulated food trays. Breakfast is served at 5:00 a.m., lunch at 10:30 a.m. and dinner at 4:30 p.m. It takes members of staff approximately one hour to feed the detainees. Based upon the observation of a member of the audit team, the process of the delivery and serving of meals was performed professionally and efficiently. Tables with attached chairs are provided in spacious day rooms for dining. The detainees that the audit team observed eating appeared to feel free to talk and visit in a positive manner while eating their meals.

A number of detainees with whom the audit team spoke, complained about the food served at the facility. The experience of the audit team with regard to the detainee meals that were served during the time of the audit was not consistent with these complaints. Members of the audit team ate two separate meals during the audit and found them to be very good in both quality and quantity.

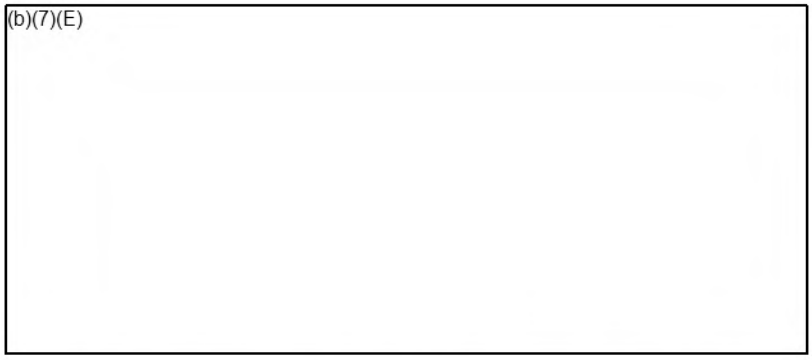
Medical Care:

Health care services at the South Texas ICE Processing Center (STIPC) are provided under contract with ICE Health Services Corps (IHSC). The ICE Health Service Corps has its own mission statement: "Protect, promote, and advance the health and safety of individuals in the custody of ICE by providing necessary health care through an integrated health care delivery system that is based on nationally-recognized correctional and detention health care standards."

The medical department appears well staffed with enough personnel to avoid mandatory overtime in order to be properly staffed. Staffing is as follows:

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AMERICAN OVERSIGHT



All medical certifications and licenses were available for review and found to be current and compliant.

The space for medical services was designed for the original capacity. With the expanded population totaling 1,800 detainees and the additional services being provided, the medical unit is beginning to stretch at its seams.

Upon arrival, all detainees are informed about how to access health services and how to utilize the medical grievance system. This information is provided via a continuous play recording and in a written handbook, which all detainees are provided. Detainees are provided an initial pre-screening within two hours of their arrival. The more comprehensive initial intake screening is completed within 12 hours of their arrival. Screenings that identify any issue are referred for health appraisal, which is completed within two days. Routine arrivals without any identified medical issues are appraised or have their records reviewed within 14 days. All appraisals are reviewed and signed by a physician. Health information is provided by way of the intake video, pamphlets, signage, and oral instruction.

There is no infirmary and no medical housing at STIPC, but there are 16 medical observation rooms that provide for the temporary housing of detainees who require short-term observation. These rooms have toilets, washbasins, and showers and can accommodate one, two or four detainees at a time. During the audit there were nine patients in the medical observation unit. There is staff sight/sound coverage 24 hours a day, seven days a week by a registered nurse or higher.

Treatment rooms are located as follows: four in Behavioral Health, three in sick call clinic, four in the main clinic, one in the medical observation unit, two in Intake, and one in the restricted housing unit (also referred to as segregation).

Medical services are accessed by signing up in the housing unit between 4:45 a.m. and 5:15 a.m. These sheets are then collected and taken to the medical sick call area. Security staff from the GEO Group escort the detainees down in groups of up to 15 at a time. As detainees are seen on the same day the sick call is requested, beginning at 5:30 a.m., there is no need for sick call requests to be triaged. Any individual who needs to be referred to a physician or mid-level provider is seen that same day or the following day.

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Approximately 1,600 sick call visits are conducted each month.

There are no co-pays associated with any of the health care services. Emergency room equipment includes, but is not limited to, an EKG, oxygen, suction, an emergency response bag, and an AED. Emergencies are responded to with the emergency response bag and a wheelchair within the required four-minute response time.

Staff nurses from IHSC draw the lab samples, spin them, and then refrigerate them until they are deposited in the Lab Corps pick up box at the entry to the facility. Samples that require to be frozen or that are related to infectious diseases are processed at the state lab. Other lab samples are processed by Lab Corps. All results are received electronically the following day. Any results that have been red flagged due to abnormal results are called in to the medical staff at STIPC immediately, with electronic report to follow.

There are two full-time x-ray technicians who work the afternoon/evening shift from 1:00 p.m. until 11:30 p.m., covering seven days a week. Their only function is to get a digital chest x-ray on every incoming detainee for purposes of tuberculosis evaluation. Tuberculin skin testing is conducted on all positive chest x-rays only. Other requested x-rays are performed at the Frio Regional Hospital that is located across the street from the facility. All x-ray results are provided within a matter of a few hours.

There is one identified communicable disease and infection control nurse, who follows written protocol for infection control. There is an established TB surveillance program, which includes the dating of multi-use vials when they are opened and discarding them after 30 days. A log is maintained for positive labs results regarding TB, MRSA, chicken pox, and STDs. The biohazard waste is under contract with Trident Solutions. The waste is collected is the red hazard bags and sharps containers. When full, they are placed in storage in the medical unit until time for the transfer to the external storage area. The biohazard waste is picked up once a month. There is a written plan for the isolation of detainees with identified communicable diseases. There are four negative pressure rooms that are tested daily. These rooms also receive an annual ventilation inspection and service.

All facility staff and detainees are tested annually for TB. Facility staff are offered the hep B vaccine.

Chronic care clinics at STIPC include Asthma, HIV, hypertension/cardiac, seizures, pregnancy, TB, diabetes, and hyperlipemia. There are no in-house specialty clinics, and tele-health is not utilized for medical health services. Outside referrals are often scheduled the day after the referral is made, with the initial appointment scheduled for within one week. As a result, there were only 33 outstanding consults waiting to be seen and none waiting to be scheduled.

AMERICAN OVERSIGHT

Outside referrals are sent to one of the local hospitals, with the majority being sent to the Frio Regional Hospital. The medical need and availability of specialist determines where some consults are referred.

There are four AEDs, one each located in the medical trauma room, on in the CAPS (Criminal Alien Processing Services) area, one in Master Control, and the fourth located in room 104, which is sick call room within a multi-purpose area in the segregation unit. All medical staff are CPR certified. The GEO security staff receive annual CPR training.

An on-site pharmacy is staffed Monday through Friday, ten hours each day, with the pharmacists and technicians working over-lapped four-day weeks. The pharmacy maintains a bulk stock of common formulary medications. Current licensing was displayed. Medications are obtained from a formulary that is established between IHSC and McKesson. There is some night stock of available medications for "after hours" if needed. STAT orders are filled by Frio Regional Hospital, H.E.B. drugstore, or Walmart, respectively.

The pharmacy was clean and well organized. All medications were properly stored with narcotics being additionally secured. Expired/discontinued medications are gathered at the pharmacy until the collecting container is full, and then it is sent back to the central pharmacy for disposal.

The daily-issue controlled medications were properly secured behind the nurse's station, being in a medication safe that has two separate locking doors inside a locking cabinet in a room that is kept locked with restricted access. These medications are perpetually inventoried by two licensed health staff and are documented from entry into the facility through administration to the detainee or its destruction. There were no expired medications in use. Medications with restricted temperature ranges were found to be properly stored in a refrigerator designated for that purpose. Temperatures are checked and recorded daily. Open vials therein were dated and initialed upon opening.

Medications are delivered to the detainees in their housing units by nurses using a medication cart four times a day (9:00 a.m., 12:00 p.m., 4:00 p.m., 9:00 p.m.). Any prescribed narcotics are double locked on this cart. An electronic medication tracking system allows for cell-side recording of dispensing and compliance. Controlled medications are crushed prior to dispensing. Other medications are floated before ingesting. Security staff observes all intake of medications to ensure compliance. Any medication refusals are documented immediately cell-site into the electronic MARS system. Detainees can self-dispense medications such as antibiotics, anti-hypertensive, and Glucotrol.

Detainees are offered the opportunity to purchase some over-the-counter medications through commissary purchase.

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Available items are alcohol-free mouthwash, toothpaste, floss loops, generic Tylenol, Ibuprofen, Rolaids, hemorrhoid ointment, antibiotic ointment, cough drops, and multi-vitamin.

Inventories of the sharps and narcotics were observed being conducted. There was one question during the count that was very quickly resolved. (A recently removed insulin syringe not yet recorded). A count of prescribed medications was also observed with no concerns. All nurses conducting both counts were efficient and followed proper procedures.

Medical personnel visit the segregation unit daily at 5:00 a.m. Sick call is conducted during each round.

The facility is compliant with their alcohol/drug withdrawal guidelines, which include medical supervision.

All female detainees arriving at this facility are tested for pregnancy. No children or nursing infants are received here. Females who test positive for pregnancy are expedited by ICE for transfer or release. Until that time, they are referred immediately to a doctor for initial evaluation and the provision of vitamins and other prenatal care. A community obstetrics provider conducts an ultrasound and complete pelvic exam.

To achieve continuity of care on releasing or transferring detainees, those who are on HIV and/or TB treatment protocol are provided a 30-day supply of medications along with a referral to their country's medical system. All other chronic care conditions are provided a 14-day supply of medications. Releasing detainees are also given instruction on how to access their electronic medical records to ensure consistent care.

Internal and external peer reviews are conducted per policy and standard requirements. The multi-disciplinary team, which includes security staff, meets quarterly regarding infectious disease issues and trends. There was a recent 13-month active mumps occurrence with one possible active mumps case under observation. During the outbreak housing units were placed under quarantine status to prevent continued spreading of the disease.

An effective quality improvement committee is pro-active in identifying opportunities for improvement, developing corrective action plans, executing them and then observing the results. Yearly goals are established and monitored through program review. The medical department administration is responsible for receiving, investigating, and responding to all medical grievances.

Medical restraints are not used at STIPC. Neither students, interns, or detainees are used in the provision of health care, nor are detainees used in the provision of familial duties.

AMERICAN OVERSIGHT

It is the responsibility of ICE personnel, and not the facility GEO or IHSC staff, to notify the designated individuals regarding the serious illness, injury or death of any detainee. Informed consents are used as required, as are releases of information.

The medical records are in electronic form and are easily maintained separately from the detainee's institutional record. All non-emergent health-care contacts are conducted in confidential settings. The intake screening includes identifying potential sexual perpetrators and victims. This information is used when determining housing assignments.

Dental

There is a small, one-chair dental unit that is staffed with one full-time and one part-time dentists and two full-time dental assistants. There is no hygienist, but a dentist will do cleanings for any detainee after one year of being in the facility. A dental screening is conducted as part of the medical intake screening with full dental exams being performed within 14 days, well within the 30-day standard requirement. The dental unit does not have any waiting list for services as all patients are seen very quickly. There is no co-pay for any dental services.

The dental unit operates from 7:00 a.m. through 5:30 p.m. The very experienced dentist(s) perform extractions, root canals, fillings, and cleanings. Targeted and panoramic digital x-rays are completed on-site. Only the most extreme cases would be referred to an off-site oral surgeon for treatment. Due to the short-term retention of detainees at STIPC, the time constraints prevent initiating any dentures or partials. Detainees who arrive with dentures or partials that may need adjustment or repair may present their needs at dental sick call.

Dental instruments are sterilized and packaged after each use. A review of the dental instruments and their inventory was conducted with no discrepancies.

The members of the dental staff were delightful to engage with. Their small space was very clean and well organized, making use of every inch of space. Their positive demeanors reflected well on their working environment.

Mental Health

Mental health services are provided by (b)(7)(E) (b)(7)(E) Staff schedules overlap to provide services from 7:00 a.m. through 5:30 p.m. seven days a week. Individual treatment plans, to include crisis intervention, counseling, and medications, are developed for each patient. Telehealth is available and utilized. Weekly visits by the mental health personnel are made to the segregation unit, with additional visits being made as needed.

AMERICAN OVERSIGHT

Comprehensive suicide prevention/intervention training is in place with annual training provided to staff. When appropriate, detainees are provided safety garments that help to keep the detainee safe. During the audit there were two detainees on "constant watch", one who was dressed in the 'suicide smock'. The smock did not lend toward any embarrassment of the wearer.

Any detainee who is referred for mental health treatment does receive a comprehensive evaluation by a licensed mental health professional. The evaluation is inclusive of past and present mental health screenings, appraisals, diagnostic and assessment tests, and behavior observations. This intensive evaluation is completed within 14 days of the referral request date and is used to develop an overall treatment and/or management plan. Any detainee who exhibits needs for psychiatric treatment that exceed the mental health care that the facility can provide is referred to a more appropriate facility.

Medical Outcome Measures

After reviewing the information provided and following up with the Commander of IHSC, there remains little doubt that the best possible practices are in place to prevent or control any communicable disease breakouts, to provide appropriate medical treatment and dietary requirements for those with chronic conditions, and for all health care to be provided by properly trained and licensed professional staff.

All incoming detainees receive a chest x-ray to determine any existing of tuberculosis, as oral histories are not necessarily reliable. Over 3,000 chest x-rays were taken, and of those, there were 56 (4C(1)) with positive results who required a follow-up tuberculin skin test. All those are reported as conversions (4C(3)) as previous status was unknown. Due to the short length of time that the majority of detainees remain at STIPC, only one (4C(4)) of the 131 (4C(4b)) was able to complete the prophylaxis treatment. Any detainee who transferred or was released was provided an appropriate amount of medication to sustain their treatment until they were able to be in contact with their next provider.

There were 11 suicide attempts during the previous 12 months (4C(9)). There were no deaths as a result of these attempts during this same time period.

Medically prescribed diets are 100% compliant because all meals are individually prepared and delivered to the housing units with diet meals identified by recipient.

Section 4C(33) indicates three pharmacy dispensing errors in the past 12 months. These were due to name errors and were corrected prior to any patient receiving the incorrect medication.

Nursing medication errors (4C(34)) is reported as 55. A recent transition to an electronic medication system (sMARt) was both contributory to these errors and beneficial in the timely correction of other errors.

AMERICAN OVERSIGHT

There were: nine medications not verified in the sMARt system, leading to missed doses; seven missed doses due strictly to human errors; 11 incorrect doses; three wrong patients; six pharmacy errors; five untimely medications/immunization; five wrong medications; with other errors being such things as incorrect discontinuations, excessive insulin in a specified time frame; transcription error; lack of documentation; providing antibiotics as keep-on-person instead of the prescribed nurse-administered. It is expected that with the current level of familiarity on the sMARt medication system that these reportable errors will show a significant reduction during the upcoming accreditation cycles.

Regarding PREA matters, the facility reported a total of five alleged sexual misconduct between staff and detainees in the past 12 months, with one being a member of the medical staff. At the time of reporting this information there were no substantiated allegations. The facility also reported, and confirmed, that there were no identified sexual predators who were detained at the STIPC.

Detainee grievances regarding access to health care totaled 100 with seven found in favor of the detainee(s); there were also 64 grievances related to the quality of health care with five being found in favor of the detainee(s).

Three of the favorable grievances were concerning the length of time detainees were waiting for tooth extractions (from 19 to 29 days in September and October 2019).
A segregation detainee requested medical services outside of established sick call rounds. The detainee was referred to the procedures outlined in the detainee handbook and was seen the following day.

A complaint that keep-on-person medications were not provided was favorable. After an investigation the pharmacy provided the medication.

Approved contacts were not received within one month. The grievance investigation noted an expected delivery time of 2-3 weeks following the filing of the grievance.

A lactose-free diet was requested via the grievance procedure. Upon evaluation by a provider on the date of receipt of the grievance, the matter was resolved.

Daily wound care had been ordered. A grievance was filed when this did not occur. The nursing schedule was updated to include daily wound care as ordered.

Lab supplies were not available for a scheduled lab appointment. The supplies were obtained, and the detainee was rescheduled.

Upon returning to STIPC from an outside medical encounter, the detainee was not seen by the medical provider. An appointment was subsequently scheduled.

AMERICAN OVERSIGHT

One detainee encountered a mental health provider in the hallway and wanted services. The detainee was scheduled with a one-on-one appointment.

Another detainee wanted a sooner appointment with mental health to discuss his inability to sleep and general anxiety related to his immigration stats. The detainee was evaluated upon receipt of the grievance (the same day).

A female detainee with a history of sexual assault (victim) stated that she was mistreated by an offsite OB/GYN physician, and that he caused her psychological trauma. She was referred to mental health and the incident was reported to ICE and an investigation was completed. The OB/GYN was terminated.

Grievant stated that he did not receive his prescribed medications during pill pass. The matter was discussed with nursing staff who were advised to exhaust attempts to administer prescribed medications.

Due to an error identified in the electronic health record, a detainee did not receive his prescribed medications. The error was corrected, and the medication was provided.

A sick call encounter resulted in a referral to a provider. A grievance was filed when the detainee was not seen. An appointment was subsequently scheduled to see the provider in a timely fashion.

Recreation:

(b)(7)(E) Recreation Specialists, who have all completed an eight-hour course with regard to recreation, oversee the Recreation Department. Detainees do not assist the Specialists. The facility provides ample space for recreation. Outdoor recreation yards adjoin all of the dormitories, which have open grates at the top allowing sunlight and fresh air. Detainees are able to access the recreation yards seven days a week from 7:00 a.m. until dusk. During the tour of the facility, the audit team observed numerous detainees playing basketball in the recreation yards. The facility also has an impressive outside 22,000 square foot recreation yard with a full size soccer field (artificial turf), shade pavilions, exercise stations, and picnic tables. The large outside recreation yard is available to a housing unit only once every three weeks on a rotating basis. Some detainees complained that they received use of the soccer field only once every four weeks. Basketball, handball, soccer, body weight exercises, running and walking are the primary physical activities engaged in by detainees. Tournaments are periodically held in basketball and soccer. The facility also has three multi-purpose rooms that are utilized for activities such as yoga, bingo, and chess and checkers tournaments.

AMERICAN OVERSIGHT

Recreation activities are also available in the housing unit dayrooms. Recreation within the housing unit includes cards and games such as UNO, checkers, chess, Connect4, Scrabble, SkipBo, Chinese checkers, dominos and monopoly. Each housing unit has two televisions.

Religious Programming:

STIPC provides a full time Chaplain to serve the spiritual and pastoral needs of its detainees. The Chaplain supervises and coordinates the various religious activities, self-help programs, and services to meet the basic belief systems of each religious group within the facility. At the time of the audit, services were being provided for the following belief systems: Protestant, Catholic (Roman and Eastern Rite), Jewish, Hindu, Buddhist, Sikh and Muslim. Opportunities for creative endeavors are also provided, including the use of musical instruments. The facility also provides opportunities for detainee-led bible study and prayer groups within the housing units. Each detainee is allowed to practice their religious beliefs as long as they do not compromise the good order and security of the facility. All religious services and programming take place in three multipurpose rooms. Offenders have access to a small religious library that includes books and audio visual aids.

The Chaplain endeavors to maintain a committed group of volunteers who assist in providing the religious services and programs in which detainees are engaged. Currently, there are 17 volunteers actively engaged in serving the detainees. Volunteers receive orientation prior to being allowed to minister to detainees and annual training thereafter. The training was documented.

When there has been a death or serious illness in a detainee's family or close social circle, the Chaplain provides notification and support for the detainee upon request. The Chaplain provides spiritual counseling for the detainee population upon request.

Offender Work Programs:

Detainees may volunteer to work within the facility by submitting a completed Volunteer Work Program Application, which outlines in great detail the screening process, rules and compensation related to the Work Program. Before being assigned to a job within the facility, a detainee must receive a medical clearance and pass a background review.

The Detainee Jobs List includes: Hallway Cleaner, Tray Pusher, Kitchen, Laundry, Barber Shop, Intake Cleaners, Hygiene, Paint Crew and Shower Crew. Level three detainees are eligible only for cleaning jobs in the living areas and hallways. Detainees are paid $3.00 per day for all work assignments, with the exception of dorm porters who are paid only a $1.00 day. At the time of the audit, 32.10% of the detainees housed at the facility were assigned to jobs.

AMERICAN OVERSIGHT

During the tours of the facility, the audit team observed numerous detainees actively engaged in constructive work.

Academic and Vocational Education:

Due to the length of stay of the detainees, there are no academic or vocational education programs at the facility.

Social Services:

Detainees receive a free three-minute phone call at intake, thereby allowing them to contact family within seventy-two hours of their arrival at the facility. Following the initial phone call, detainees can make collect phone calls or use purchased phone minutes to make phone calls. Each living unit has eight to ten telephones (Talton Communications) that detainees are free to use every day from 8:00 a.m. to lights out. The housing units also have a monitor that allows the detainee to engage in video visitation with members of their family. All phone calls, except those with attorneys, are monitored and recorded.

Mail is processed in the central mailroom Monday thru Friday and delivered to the detainee the same day it is received. The facility averages approximately 50 pieces of incoming detainee mail daily. Incoming mail is passed through a metal detector, opened and searched. Detainees seal outgoing mail. For mail to be treated as special correspondence or legal mail, the name, title and office of the sender or the recipient must be clearly identified on the envelope to provide clear indication the mail is being received from or being sent to an attorney or other legal representative. Indigent detainees (less than $15) may receive five stamps a week.

Social service information regarding such things as suicide prevention, sexual abuse prevention, sexual assault prevention and immigration is made available to detainees through housing unit bulletin boards and other means. Housing unit bulletin boards also contain information with regard to the building schedule, visitation, mail, recreation schedule, religious services schedule and sick call.

Haircuts are available each day from 6:30 a.m. to 6:30 p.m. Individual dorms are scheduled for sessions providing time slots for 15 detainees. The barbershop engaged in proper tool control. A member of the audit team recommended that partial containers of barber chemicals be inventoried in a more precise manner. The facility was receptive to this recommendation.

Visitation:

STIPC has a non-contact visitation area (containing 15 visitation booths) that provides a comfortable atmosphere for detainees to maintain ties with members of their family and the community. Visitors have access to a waiting room, lockers and restrooms.

AMERICAN OVERSIGHT

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While there is no designated children's area, there is a children's table in a corner of the visitor's side of the visitation area. There are three vending machines in the visitation area for use by visitors. Detainees are allowed visitation with family and friends who are on their approved visitation list, as determined by ICE. Before being allowed into the visitation area, visitors must pass through a metal detector. Visiting hours are from 6:30 a.m. to 10:00 p.m., seven days a week. Visits can last for two hours, unless the Facility Administrator has approved additional time. Detainees can visit with two adults at time and as many children as can be adequately handled. One officer is posted on the detainee side of the visitation area at all times. There are two cameras located in the visitation area. During each day of the audit, the audit team observed numerous adults and children in the visitation waiting room. The officers posted in the front entrance area dealt with visitors in a very respectful, helpful and professional manner. Video visitation is available in the living areas through Talton Communications.

Library Services:

(b)(7)(E) officers are assigned to oversee library services at the facility. On Tuesday, Wednesday and Thursday each week, the assigned officers deliver leisure library books by carts to designated housing units. Detainees are able to check out two books per week for the duration of a week. Other than books on the cart, a detainee may request a book from the library. The library contains about 1,500 books. Other than English, there are books written in Vietnamese, Chinese, Russian, Spanish and Turkish. The library does not have any large print books. Detainees are able to access newspapers and magazines through the use of computer tablets that are available in the living units. An inter-library loan service is provided through the Pearsall Public Library.

In addition to the leisure library, STIPC also has a law library, which is available to detainees upon request (spots assigned pursuant to detainee levels one, two and three) from 8:00 a.m. to 6:00 p.m. on weekdays and 8:00 a.m. to 2:00 p.m. on weekends. Detainees are able to use the law library twice a week for one-hour sessions, with the option of requesting additional time. Detainees have access to various hard volumes of Law Reporters and legal research materials. To the extent that the hard volumes provided in the library are insufficient to address their legal issue needs, detainees have access to LexisNexis, a computer software research tool. There are nine computer terminals in the law library. A word processing computer, copying of documents and notary services are available through the library staff. American Gateway, a paralegal service, is available Tuesday, Wednesday and Thursday from 10:00 a.m. to12:00 p.m.

Laundry:

(b)(7)(E)

(b)(7)(E) staff STIPC's laundry.

AMERICAN OVERSIGHT

The laundry is equipped with four commercial grade washing machines (125 lb.) and four commercial grade dryers (125 lb.). At the time of the audit, all of the washing machines and dryers were operational. The laundry operates four shifts, seven days a week. Upon arriving at STIPC, each detainee receives a standard clothing issue comprising of three sets of uniform, socks, underwear, and shirts, one towel, one wash cloth, two sheets, one blanket, one pair of shoes, and a laundry bag. Linen exchange is provided once a week on a one to one exchange. Blankets are exchanged monthly for laundering. Uniforms are also exchanged/reissued as needed. Medical laundry is submitted in a degradable bag and washed in a separate washing machine. Laundry carts are routinely sanitized. Personal property that is stored in the property room is laundered prior to storage. The personal property area contains one washer and two dryers.

The laundry area was well maintained and very clean. Lint traps are cleaned at the conclusion of all four shifts. Bleach, detergent and other chemicals were securely locked away. Inventories were appropriately accounted for and maintained. All laundry chemicals are dispensed directly to the machines by an automated dispensing system. Issue/return logs and inventory logs were present and appropriately maintained. Through specific inquiry, the audit team was able to verify the inventory and location of tools. Inventory of all tools are cleared at the end of every shift.

F. Examination of Records

Following the facility tour, the team proceeded to the conference room to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has zero notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

   Over the last three years, the unit has had no class action lawsuits or adverse judgments.

2. Significant Incidents/Outcome Measures

   The Significant Incident Summary statistics did not indicate any problem areas at the facility.

   Non-medically related Outcome Measures statistics were reasonable for the size and population of this facility and appeared to be appropriate. Medically related Outcome Measures Statistics are discussed in the Medical Care section of the report.

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3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

(b)(7)(E)

4. Shifts

a. Day Shift – 5:45 a.m. to 2:15 p.m.

The audit team was present at the facility during the day shift from 8:10 a.m. to 2:15 p.m.

The team toured the facility and spoke to members of staff and detainees. Members of the staff were responsive and knowledgeable of their job duties. The team observed detainees working jobs, attending court, socializing and recreating. Detainees, with whom the audit team communicated, were open about sharing their observations of and experiences at the facility. There was great order and respect exhibited by the detainees. A detainee meal was eaten. The audit team reviewed standards folders.

AMERICAN OVERSIGHT

During the second day of the audit, areas were revisited, another detainee meal was eaten, a count was observed and further interviews with members of staff and detainees were conducted. The audit team continued to review standards folders.

b. Evening Shift – 1:45 p.m. to 10:15 p.m.

The audit team was present at the facility during the evening shift from 2:15 p.m. to 7:00 p.m.

The audit team continued to review files. The audit team observed in-briefing and out-briefing, where the topics covered were doctor's appointments, EMS response, appropriate length of lunches, break areas, counts, visitation procedures, proper attire and post orders. Further interviews with members of staff and detainees were conducted.

b. Night Shift – 9:45 p.m. to 6:15 a.m.

The audit team was present at the facility during the night shift from 9:45 p.m. to 10:45 p.m. A member of the audit team attended in-briefing and visited with members of the oncoming members of the security staff. A member of the audit team observed shift change in Master Control, which was carried out professionally and efficiently.

5. Status of Previously Non-compliant Standards/Plans of Action

The following standards that were previously determined to be non-compliant, remain non-compliant:

Standard #4-ALDF-4B-08
Standard #4-ALDF-4B-09
Standard #4-ALDF-5C-03

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

During the audit period, the audit team talked with approximately 50 detainees. The detainees were overwhelming positive about the staff and environment at the facility. All of the detainees spoken to stated that they felt safe at the facility. Detainees stated that for the most part, members of the staff were responsive to their problems and exhibited respect.

AMERICAN OVERSIGHT

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Some detainees complained about members of ICE staff and their lack of responsiveness to their questions and providing information about the progress of their cases. Members of the facility administration stated that members of ICE staff make weekly visits to each housing unit. Complaints were sporadic and there were no persistent complaints regarding the basic services of medical care, mail, religion, safety or visitation. The detainee population appeared to be well aware of whom the facility staff members were, and members of staff were responsive to detainee inquiries during the tours.

2. Staff Interviews

The audit team spoke to or interviewed a significant number of members of the staff. The audit team was impressed with the number of long-term employees. The audit team found members of staff to be very cooperative and responsive with regard to requests for additional documentation and to recommendations offered by the audit team. The audit team was impressed by the passion displayed by members of staff with regard to their jobs. It was clear that members of staff were very knowledgeable about their job duties and were able to articulate those duties clearly. There was a real camaraderie evidenced among members the staff. Members of the staff expressed no complaints with regard to members of management.

H. Exit Discussion

The exit interview was held in the multi-purpose area with Facility Administrator Castro and 44 members of staff in attendance. The exit interview was held at 11:30 a.m., to ensure timely arrival at the airport.

The following persons were also in attendance:

Central Region Director Contract Compliance (b)(6); (b)(7)(C)
Central Region Director of Operations (b)(6); (b)(7)(C)

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

AMERICAN OVERSIGHT

AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Adult Local Detention Facilities, 4th Edition
Supplement	2016 Standards Supplement
Facility/Program	South Texas ICE Processing Center (GEO)
Audit Dates	December 9 - 11, 2019
Auditor(s)	(b)(6); (b)(7)(C) Chairperson (b)(6); (b)(7)(C) lember Member

	MANDATORY	NON-MANDATORY
Number of Standards in Manual	60	323
Number Not Applicable	0	33
Number Applicable	60	290
Number Non-Compliance	0	3
Number in Compliance	60	287
Percentage (%) of Compliance	100%	98.9%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

AMERICAN OVERSIGHT

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

The Geo Group, Inc.
South Texas ICE Processing Center
Pearsall, Texas

December 9 - 11, 2019

Visiting Committee Findings

Non-Mandatory Standards

Non-Compliance

Standard #4-ALDF-4B-08

INMATES HAVE ACCESS TO TOILETS, AND WASHBASINS WITH TEMPERATURE CONTROLLED HOT AND COLD RUNNING WATER 24 HOURS PER DAY AND ARE ABLE TO USE TOILET FACILITIES WITHOUT STAFF ASSISTANCE WHEN THEY ARE CONFINED IN THEIR CELLS/SLEEPING AREAS. TOILETS ARE PROVIDED AT A MINIMUM RATIO OF ONE FOR EVERY 12 INMATES IN MALE FACILITIES AND ONE FOR EVERY EIGHT INMATES IN FEMALE FACILITIES AND ONE WASHBASIN FOR EVERY 12 INMATES UNLESS NATIONAL OR STATE BUILDING OR HEALTH CODES SPECIFY A DIFFERENT RATIO. URINALS MAY BE SUBSTITUTED FOR UP TO ONE-HALF OF THE TOILETS IN MALE FACILITIES. ALL HOUSING UNITS WITH THREE OR MORE INMATES HAVE A MINIMUM OF TWO TOILETS.

FINDINGS:

South Texas ICE Processing Center does not meet the required ratio of toilets and washbasins to detainees.

AGENCY RESPONSE:

Waiver Request

Detainees housed at the South Texas ICE Processing Center have access to toilets and washbasins with temperature controlled hot and cold running water twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined to their sleeping areas. Based on the original structural design of the housing units it is not structurally or financially feasible to modify the plumbing fixtures. There has not been any complaints or grievances from the detainee population regarding toilet and washbasin access.

AMERICAN OVERSIGHT

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The table below is a summary of toilets and washbasins with ratio comparison to total bed capacity:

Area/Dorm	Number of Beds	Number of Toilets	Ratio Toilet: Detainee	Number of Washbasins	Ratio Washbasin: Detainee
FA	100	5	20:1	4	25:1
FB	100	6	17:1	4	25:1
FD	100	5	20:1	4	25:1
FE	60	3	20:1	2	30
DA	100	6	17:1	6	17:1
DB	100	6	17:1	6	17:1
DC	100	6	17:1	6	17:1
DD	100	6	17:1	6	17:1
DE	64	3	21:1	3	21:1
DF	64	3	21:1	3	21:1
DG	64	3	21:1	3	21:1
DH	64	3	21:1	3	21:1
DJ	100	6	17:1	6	17:1
DK	100	6	17:1	6	17:1
DL	100	6	17:1	6	17:1
DM	100	6	17:1	6	17:1
DN	100	6	17:1	6	17:1
DP	64	3	21:1	3	21:1
DQ	64	3	21:1	3	21:1
AA	48	2	24:1	2	24:1
AB	16	1	16	2	8:1

AUDITOR'S RESPONSE:

The audit team concurs with STIPC's request for a waiver. The audit team agrees with STIPC that based on the original structural design of the housing units, it is not structurally or financially feasible to modify the plumbing fixtures of the facility. Moreover, the audit team concludes that non-compliance with this standard does not result in the detainees' quality of life being unreasonably compromised, as evidenced by the lack of complaints or grievances from the detainee population regarding toilet and washbasin access.

Standard #4-ALDF-4B-09

INMATES HAVE ACCESS TO OPERABLE SHOWERS WITH TEMPERATURE-CONTROLLED HOT AND COLD RUNNING WATER, AT A MINIMUM RATIO OF ONE SHOWER FOR EVERY TWELVE INMATES. WATER FOR SHOWERS IS THERMOSTATICALLY CONTROLLED TO TEMPERATURES RANGING FROM 100 DEGREES FAHRENHEIT TO 120 DEGREES FAHRENHEIT TO ENSURE THE SAFETY OF INMATES AND TO PROMOTE HYGIENIC PRACTICES.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001247

THESE RATIOS AND TEMPERATURES SHALL APPLY UNLESS NATIONAL OR STATE BUILDING OR HEALTH CODES SPECIFY A DIFFERENT RATIO.

FINDINGS:

South Texas ICE Processing Center does not meet the required ratio of showers to detainees.

AGENCY RESPONSE:

Waiver Request

Detainees housed at the South Texas ICE Processing Center have access dormitory showers between 06:00 hours until call for "lights out" around 22:30 hours. Detainees returning from a work assignment are afforded the opportunity to shower if they arrive after the call has been made. Based on the original structural design of the housing units it is not structurally or financially feasible to modify the plumbing fixtures. There has not been any complaints or grievances from the detainee population regarding access to showers.

The table below is a summary of the number of showers in each dormitory and the ratio of showers to maximum bed capacity.

Area/Dorm	Number of Beds	Number of Showers	Ratio Shower: Detainee
FA	100	5	20:1
FB	100	5	20:1
FD	100	5	20:1
FE	60	3	20:1
DA	100	8	13:1
DB	100	6	17:1
DC	100	6	17:1
DD	100	4	25:1
DE	64	4	16:1
DF	64	4	16:1
DG	64	4	16:1
DH	64	4	16:1
DJ	100	8	13:1
DK	100	8	13:1
DL	100	8	13:1
DM	100	8	13:1
DN	100	8	13:1
DP	64	4	16:1
DQ	64	4	16:1
AA	48	2	24:1

AMERICAN OVERSIGHT

AB	16	1	16:1

AUDITOR'S RESPONSE:

The audit team concurs with STIPC's request for a waiver. The audit team agrees with STIPC that based on the original structural design of the housing units, it is not structurally or financially feasible to modify the plumbing fixtures of the facility. Moreover, the audit team concludes that non-compliance with this standard does not result in the detainees' quality of life being unreasonably compromised, as evidenced by the lack of complaints or grievances from the detainee population regarding shower access.

Standard #4-ALDF-5C-03

BOTH OUTDOOR AND COVERED/ENCLOSED EXERCISE AREAS FOR GENERAL POPULATION INMATES ARE PROVIDED IN SUFFICIENT NUMBER TO ENSURE THAT EACH INMATE IS OFFERED AT LEAST ONE HOUR OF ACCESS DAILY. USE OF OUTDOOR AREAS IS PREFERRED BUT COVERED/ENCLOSED AREAS MUST BE AVAILABLE FOR USE IN INCLEMENT WEATHER. COVERED/ENCLOSED AREAS CAN BE DESIGNED FOR MULTIPLE USES AS LONG AS THE DESIGN AND FURNISHINGS DO NOT INTERFERE WITH SCHEDULED EXERCISE ACTIVITIES. THE MINIMUM SPACE REQUIREMENTS FOR EXERCISE AREAS ARE AS FOLLOWS:

- OUTDOOR EXERCISE AREAS IN FACILITIES WHERE 100 OR MORE INMATES UTILIZE ONE RECREATION AREA – 15 SQUARE FEET PER INMATE FOR THE MAXIMUM NUMBER OF INMATES EXPECTED TO USE THE SPACE AT ONE TIME, BUT NOT LESS THAN 1,500 SQUARE FEET OF UNENCUMBERED SPACE
- OUTDOOR EXERCISE AREAS IN FACILITIES WHERE LESS THAN 100 INMATES HAVE UNLIMITED ACCESS TO AN INDIVIDUAL RECREATION AREA – 15 SQUARE FEET PER INMATE FOR THE MAXIMUM NUMBER OF INMATES EXPECTED TO USE THE SPACE AT ONE TIME, BUT NOT LESS THAN 750 SQUARE FEET OF UNENCUMBERED SPACE
- COVERED/ENCLOSED EXERCISE AREAS IN FACILITIES WHERE 100 OR MORE INMATES UTILIZE ONE RECREATION AREA HAVE 15 SQUARE FEET PER INMATE FOR THE MAXIMUM NUMBER OF INMATES EXPECTED TO USE THE SPACE AT ONE TIME, WITH A MINIMUM CEILING HEIGHT OF 18 FEET, BUT NOT LESS THAN 1,000 SQUARE FEET OF UNENCUMBERED SPACE
- COVERED/ENCLOSED EXERCISE AREAS IN FACILITIES WHERE LESS THAN 100 INMATES UTILIZE ONE RECREATION AREA HAVE 15 SQUARE FEET PER INMATE FOR THE MAXIMUM NUMBER OF INMATES EXPECTED TO USE THE SPACE AT ONE TIME, WITH A MINIMUM CEILING HEIGHT OF 18 FEET, BUT NOT LESS THAN 500 SQUARE FEET OF UNENCUMBERED SPACE.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001249

FINDINGS:

South Texas ICE Processing Center's outdoor recreation areas (unit recreation yards) do not provide the square footage requirement by the standard. South Texas ICE Processing Center does not have an indoor recreation area.

AGENCY RESPONSE:

Waiver Request

Recreation yards are adjoining the dormitory with open and easy access to all detainees from the hours of 08:00 throughout the day until 18:00 hours when the daylight has dissipated. The exercise yard is available to resident detainees seven (7) days a week. At any given time, there will be no more than 10% to 15% of a dorm's residents on the yard. Based on the original structural design of the housing units it is not structurally or financially feasible to modify the recreation space. There has not been any complaints or grievances from the detainee population regarding recreation area size.

Based in the finding presented above it is requested that a waiver for a plan of action be granted to South Texas ICE Processing Center.

AUDITOR'S RESPONSE:

The audit team concurs with STIPC's request for a waiver. The audit team agrees with STIPC that based on the original structural design of the housing units, it is not structurally or financially feasible to modify the recreation space of the facility. Moreover, the audit team concludes that non-compliance with this standard does not result in the detainees' quality of life being unreasonably compromised, as evidenced by the lack of complaints or grievances from the detainee population regarding recreation area size or lack of and indoor recreation area.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001250

COMMISSION ON ACCREDITATION FOR CORRECTIONS

The Geo Group, Inc.
South Texas ICE Processing Center
Pearsall, Texas

December 9 - 11, 2019

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-2A-36

INMATES PARTICIPATING IN WORK OR EDUCATIONAL RELEASE PROGRAMS ARE SEPARATED FROM INMATES IN THE GENERAL POPULATION.

FINDINGS:

Since the stay of detainees being housed at South Texas ICE Processing Center is of short duration, there is no work or educational release program.

Standard #4-ALDF-2A-38

IF YOUTHFUL OFFENDERS ARE HOUSED IN THE FACILITY, THEY ARE HOUSED IN A SPECIALIZED UNIT FOR YOUTHFUL OFFENDERS EXCEPT WHEN:

- VIOLENT, PREDATORY YOUTHFUL OFFENDER POSES AN UNDUE RISK OF HARM TO OTHERS WITHIN THE SPECIALIZED UNIT, OR
- A QUALIFIED MEDICAL OR MENTAL-HEALTH SPECIALIST DOCUMENTS THAT THE YOUTHFUL OFFENDER WOULD BENEFIT FROM PLACEMENT OUTSIDE THE UNIT

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001251

A WRITTEN STATEMENT IS PREPARED DESCRIBING THE SPECIFIC REASONS FOR HOUSING A YOUTHFUL OFFENDER OUTSIDE THE SPECIALIZED UNIT AND A CASE-MANAGEMENT PLAN SPECIFYING WHAT BEHAVIORS NEED TO BE MODIFIED AND HOW THE YOUTHFUL OFFENDER MAY RETURN TO THE UNIT. THE STATEMENT OF REASONS AND CASE-MANAGEMENT PLAN MUST BE APPROVED BY THE FACILITY ADMINISTRATOR OR HIS/HER DESIGNEE. CASES ARE REVIEWED AT LEAST QUARTERLY BY THE CASE MANAGER, THE ADMINISTRATOR OR HIS OR HER DESIGNEE, AND THE YOUTHFUL OFFENDER TO DETERMINE WHETHER A YOUTHFUL OFFENDER SHOULD BE RETURNED TO THE SPECIALIZED UNIT.

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

Standard #4-ALDF-2A-39

DIRECT SUPERVISION IS EMPLOYED IN THE SPECIALIZED UNIT TO ENSURE THE SAFETY AND SECURITY OF YOUTHFUL OFFENDERS.

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

Standard #4-ALDF-2A-40

CLASSIFICATION PLANS FOR YOUTHFUL OFFENDERS DETERMINE LEVEL OF RISK AND PROGRAM NEEDS DEVELOPMENTALLY APPROPRIATE FOR ADOLESCENTS. CLASSIFICATION PLANS INCLUDE CONSIDERATION OF PHYSICAL, MENTAL, SOCIAL, AND EDUCATIONAL MATURITY OF THE YOUTHFUL OFFENDER.

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

Standard #4-ALDF-2A-41

ADEQUATE PROGRAM SPACE IS PROVIDED TO MEET THE PHYSICAL, SOCIAL, AND EMOTIONAL NEEDS OF YOUTHFUL OFFENDERS AND ALLOWS FOR THEIR PERSONAL INTERACTIONS AND GROUP ORIENTED ACTIVITIES.

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

AMERICAN OVERSIGHT

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Standard #4-ALDF-2A-42

YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT FOR YOUTHFUL INMATES HAVE NO MORE THAN INCIDENTAL SIGHT OR SOUND CONTACT WITH ADULT INMATES FROM OUTSIDE THE UNIT IN LIVING, PROGRAM, DINING, OR OTHER COMMON AREAS OF THE FACILITY. ANY OTHER SIGHT OR SOUND CONTACT IS MINIMIZED, BRIEF, AND IN CONFORMANCE WITH APPLICABLE LEGAL REQUIREMENTS.

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

Standard #4-ALDF-2A-43

PROGRAM PERSONNEL WHO WORK WITH YOUTHFUL OFFENDERS ARE TRAINED IN THE DEVELOPMENTAL, SAFETY, AND OTHER SPECIFIC NEEDS OF YOUTHFUL OFFENDERS. WRITTEN JOB DESCRIPTIONS AND QUALIFICATIONS REQUIRE TRAINING FOR STAFF WHO ARE RESPONSIBLE FOR PROGRAMMING OF YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT BEFORE BEING ASSIGNED TO WORK WITH YOUTHFUL OFFENDERS. TRAINING INCLUDES, BUT IS NOT LIMITED TO THE FOLLOWING AREAS:

- ADOLESCENT DEVELOPMENT
- EDUCATIONAL PROGRAMMING
- CULTURAL AWARENESS
- CRISIS PREVENTION AND INTERVENTION
- LEGAL ISSUES
- HOUSING AND PHYSICAL PLANT
- POLICIES AND PROCEDURES
- MANAGEMENT OF, AND PROGRAMMING FOR, SEX OFFENDERS
- SUBSTANCE-ABUSE SERVICES
- COGNITIVE BEHAVIORAL INTERVENTIONS, INCLUDING ANGER MANAGEMENT, SOCIAL-SKILLS TRAINING, PROBLEM SOLVING
- RESISTING PEER PRESSURE
- SUICIDE PREVENTION
- NUTRITION
- MENTAL-HEALTH ISSUES
- GENDER-SPECIFIC ISSUES
- CASE-MANAGEMENT PLANNING AND IMPLEMENTATION

FINDINGS:

South Texas ICE Processing Center does not youthful offenders.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001253

Standard #4-ALDF-2C-02

WHEN A CANINE UNIT IS OPERATED BY THE FACILITY:

- THERE IS A MISSION STATEMENT, INCLUDING GOALS AND OBJECTIVES
- THE CIRCUMSTANCES IN WHICH CANINE UNITS MAY BE USED ARE CLEARLY DEFINED
- EMERGENCY PLANS ARE INTEGRATED INTO THE OVERALL EMERGENCY PLANS OF THE FACILITY
- THERE ARE CRITERIA FOR SELECTING, TRAINING AND CARING FOR ANIMALS
- THERE ARE CRITERIA FOR THE SELECTION, TRAINING, AND PHYSICAL FITNESS OF HANDLERS
- THERE IS AN APPROVED SANITATION PLAN THAT COVERS INSPECTION, HOUSING, TRANSPORTATION AND DAILY GROOMING FOR THE ANIMALS
- THERE ARE DAILY AND CURRENT RECORDS ON TRAINING, CARE OF DOGS AND SIGNIFICANT EVENTS

FINDINGS:

South Texas ICE Processing Center does not have a canine unit.

Standard #4-ALDF-4A-14

WHEN REQUIRED BY STATUTE, FOOD PRODUCTS THAT ARE GROWN OR PRODUCED WITHIN THE SYSTEM ARE INSPECTED AND APPROVED BY THE APPROPRIATE GOVERNMENT AGENCY; THERE IS A DISTRIBUTION SYSTEM THAT ENSURES PROMPT DELIVERY OF FOODSTUFFS TO FACILITY KITCHENS.

FINDINGS:

South Texas ICE Processing Center does not grow food products.

Standard #4-ALDF-4C-02

WHEN MEDICAL CO-PAYMENT FEES ARE IMPOSED, THE PROGRAM ENSURES THAT, AT A MINIMUM:

- ALL INMATES ARE ADVISED, IN WRITING, AT THE TIME OF ADMISSION TO THE FACILITY OF THE GUIDELINES OF THE CO-PAYMENT PROGRAM

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001254

- CO-PAYMENT FEES ARE WAIVED WHEN APPOINTMENTS OR SERVICES, INCLUDING FOLLOW-UP APPOINTMENTS, ARE INITIATED BY MEDICAL STAFF

FINDINGS:

South Texas ICE Processing Center does not assess medical copays.

Standard #4-ALDF-4D-10

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A WRITTEN AGREEMENT BETWEEN THE FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS THE SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS OR INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

South Texas ICE Processing Center does not use students, interns or residents in the delivery of health care.

Standard #4-ALDF-4D-11

UNLESS PROHIBITED BY STATE LAW, INMATES, UNDER STAFF SUPERVISION, MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE THE FOLLOWING:

- PEER SUPPORT AND EDUCATION
- HOSPICE ACTIVITIES
- ASSISTING IMPAIRED INMATES ON A ONE-ON-ONE BASIS WITH ACTIVITIES OF DAILY LIVING
- SERVING AS A SUICIDE COMPANION IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF A SUICIDE PREVENTION PLAN
- HANDLING DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITIZING AND CLEANING, WHEN DIRECTLY SUPERVISED AND IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES, WHILE IN A DENTAL ASSISTANTS TRAINING PROGRAM CERTIFIED BY THE STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001255

INMATES ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMINING ACCESS OF OTHER INMATES TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION, BY SPECIALLY TRAINED STAFF, IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

Detainees at the South Texas ICE Processing Center do not perform familial duties.

Standard #4-ALDF-4D-12

INDIVIDUALS DESIGNATED BY THE INMATE ARE NOTIFIED IN CASE OF SERIOUS ILLNESS, SERIOUS INJURY, OR DEATH, UNLESS SECURITY REASONS DICTATE OTHERWISE. IF POSSIBLE, PERMISSION FOR NOTIFICATION IS OBTAINED FROM THE INMATE.

FINDINGS:

Members of staff of the South Texas ICE Processing Center do not make the notifications required by this standard. Members of ICE staff make the notifications required by this standard.

Standard #4-ALDF-5A-04

INMATES WITH DRUG AND ALCOHOL ADDICTION PROBLEMS ARE PROVIDED WITH SUBSTANCE ABUSE PROGRAMS, TO INCLUDE MONITORING AND DRUG TESTING.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there is no substance abuse program.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001256

Standard #4-ALDF-5A-05

THERE IS A TREATMENT PHILOSOPHY WITHIN THE CONTEXT OF THE TOTAL CORRECTIONAL SYSTEM AS WELL AS GOALS AND MEASURABLE OBJECTIVES. THESE DOCUMENTS ARE REVIEWED AT LEAST ANNUALLY AND UPDATED AS NEEDED.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there is no therapeutic treatment program.

Standard #4-ALDF-5A-06

THERE IS AN APPROPRIATE RANGE OF PRIMARY TREATMENT SERVICES FOR ALCOHOL AND OTHER SUBSTANCE-ABUSING INMATES THAT INCLUDE, AT A MINIMUM, THE FOLLOWING:

- INMATE DIAGNOSIS
- IDENTIFIED PROBLEM AREAS
- INDIVIDUAL TREATMENT OBJECTIVES
- TREATMENT GOALS
- COUNSELING NEEDS
- DRUG EDUCATION PLAN
- RELAPSE PREVENTION AND MANAGEMENT
- CULTURALLY SENSITIVE TREATMENT OBJECTIVES, AS APPROPRIATE
- THE PROVISION OF SELF-HELP GROUPS AS AN ADJUNCT TO TREATMENT
- PRERELEASE AND TRANSITIONAL SERVICE NEEDS
- COORDINATION EFFORTS WITH COMMUNITY SUPERVISION AND TREATMENT STAFF DURING THE PRERELEASE PHASE TO ENSURE A CONTINUUM OF SUPERVISION AND TREATMENT

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there is no alcohol or substance abuse program.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001257

Standard #4-ALDF-5A-07

THE FACILITY USES A COORDINATED STAFF APPROACH TO DELIVER TREATMENT SERVICES. THIS APPROACH TO SERVICE DELIVERY IS DOCUMENTED IN TREATMENT PLANNING CONFERENCES AND IN INDIVIDUAL TREATMENT FILES.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there are no treatment services.

Standard #4-ALDF-5A-08

THERE ARE INCENTIVES FOR TARGETED TREATMENT PROGRAMS TO INCREASE AND MAINTAIN THE INMATE'S MOTIVATION FOR TREATMENT.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there are no treatment programs.

Standard #4-ALDF-5A-09

INMATES HAVE ACCESS TO EDUCATIONAL PROGRAMS AND, WHEN AVAILABLE, TO VOCATIONAL COUNSELING AND VOCATIONAL TRAINING. EDUCATIONAL AND VOCATIONAL PROGRAMS ADDRESS THE NEEDS OF THE INMATE POPULATION.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there are no vocational programs.

Standard #4-ALDF-5A-10

IN FACILITIES OFFERING ACADEMIC AND VOCATIONAL TRAINING PROGRAMS, CLASSROOMS ARE DESIGNED IN CONSULTATION WITH SCHOOL AUTHORITIES. (RENOVATION, ADDITION, NEW CONSTRUCTION ONLY)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001258

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the short duration of care, there are no educational or vocational training programs.

Standard #4-ALDF-5B-14

WHEN THE FACILITY IS DESIGNATED TO OPERATE ANY TYPE OF PRETRIAL INTERVENTION SERVICE OR OTHER RELEASE PROGRAMS, ITS AUTHORITY AND RESPONSIBILITY ARE STATED BY STATUTE OR ADMINISTRATIVE REGULATION.

FINDINGS:

The South Texas ICE Processing Center is not designated to operate any pre-trial intervention service or other release program.

Standard #4-ALDF-5B-15

WHEN A PRETRIAL INTERVENTION PROGRAM, DIVERSION PROGRAM, PRETRIAL RELEASE PROGRAM, OR SUPERVISED RELEASE PROGRAM IS CONDUCTED IN THE FACILITY, SUFFICIENT STAFF, SPACE, AND EQUIPMENT ARE PROVIDED TO SERVICE THE PROGRAM.

FINDINGS:

The South Texas ICE Processing Center does not conduct any pre-trial intervention program, diversion program, pretrial release program or supervised release program.

Standard #4-ALDF-5B-16

WHERE TEMPORARY RELEASE PROGRAMS EXIST, THE PROGRAMS HAVE THE FOLLOWING ELEMENTS:

- WRITTEN OPERATIONAL PROCEDURES
- CAREFUL SCREENING AND SELECTION PROCEDURES
- WRITTEN RULES OF INMATE CONDUCT
- A SYSTEM FOR EVALUATING PROGRAM EFFECTIVENESS
- EFFORTS TO OBTAIN COMMUNITY COOPERATION AND SUPPORT

FINDINGS:

The South Texas ICE Processing Center does not have any temporary release programs.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001259

Standard #4-ALDF-5B-17

WHERE WORK RELEASE AND/OR EDUCATIONAL RELEASE ARE AUTHORIZED, THE FACILITY ADMINISTRATOR HAS AUTHORITY TO APPROVE OR DISAPPROVE PARTICIPATION FOR EACH INMATE.

FINDINGS:

The South Texas ICE Processing Center is not authorized to operate any work release or educational release programs.

Standard #4-ALDF-5C-07

THE FACILITY CAN REQUIRE ALL SENTENCED INMATES TO WORK IF THEY ARE NOT ASSIGNED TO PROGRAMS.

FINDINGS:

The South Texas ICE Processing Center does not have sentenced inmates.

Standard #4-ALDF-5C-09

WHERE STATUTE PERMITS, INMATES ARE ASSIGNED TO PUBLIC WORKS AND COMMUNITY SERVICE PROJECTS.

FINDINGS:

The South Texas ICE Processing Center is not allowed by statute to assign inmates to public works and community service projects.

Standard #4-ALDF-5C-13

WHERE AN INDUSTRIES PROGRAM EXISTS, ITS ESTABLISHMENT IS AUTHORIZED AND AREAS OF AUTHORITY, RESPONSIBILITY, AND ACCOUNTABILITY ARE DELINEATED.

FINDINGS:

The South Texas ICE Processing Center does not have an industries program.

Standard #4-ALDF-5C-14

THE NUMBER OF INMATES ASSIGNED TO INDUSTRIES OPERATIONS MEETS THE REALISTIC WORKLOAD NEEDS OF EACH OPERATING UNIT.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001260

FINDINGS:

The South Texas ICE Processing Center does not have an industries program.

Standard #4-ALDF-5C-15

THERE IS A COMPREHENSIVE QUALITY CONTROL PROCESS.

FINDINGS:

The South Texas ICE Processing Center does not have an industries program.

Standard #4-ALDF-5C-16

A COST ACCOUNTING SYSTEM FOR EACH INDUSTRIES UNIT IS DESIGNED, IMPLEMENTED, AND MAINTAINED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.

FINDINGS:

The South Texas ICE Processing Center does not have an industries program.

Standard #4-ALDF-6B-06

APPROPRIATELY TRAINED INDIVIDUALS ARE ASSIGNED TO ASSIST DISABLED INMATES WHO CANNOT OTHERWISE PERFORM BASIC LIFE FUNCTIONS.

FINDINGS:

The South Texas ICE Processing Center does not house detainees who cannot perform basic life functions.

Standard #4-ALDF-6D-01

THE FACILITY PROVIDES SERVICES AND OPPORTUNITIES THAT ENCOURAGE INMATES TO TAKE RESPONSIBILITY FOR THEIR ACTIONS. OPPORTUNITIES ARE BASED UPON VICTIM AND COMMUNITY INPUT AND ARE FASHIONED IN A WAY THAT SEEKS TO AMELIORATE THE HARM DONE.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the nature of confinement, the requirements of this standard do not apply.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001261

Standard #4-ALDF-7F-02

CONSISTENT WITH THE LAWS OF THE JURISDICTION, THERE IS A SYSTEM FOR PROVIDING NOTIFICATION TO THE REGISTERED VICTIM(S) OF A CRIME UPON THE RELEASE FROM CONFINEMENT OF THE CONVICTED INMATE OR IN THE EVENT OF AN ESCAPE. FOLLOW UP NOTIFICATION TO THE VICTIM(S) OCCURS WHEN ESCAPEES ARE RETURNED TO CUSTODY.

FINDINGS:

The South Texas ICE Processing Center is under contract with DHS and ICE to provide short-term detention for individuals who are awaiting deportation hearings. Due to the nature of confinement, there are no registered victims.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001262

Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: South Texas ICE Processing Center (GEO)
Reporting Period: November 2018 - October 2019

Incident Type	Months ⇨	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender/ Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*														0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Name of Facility: South Texas ICE Processing Center
Date: 11/22/19
Number of Months Data Collected: 12 (November 1, 2018 - October 31, 2019)

		ALDF Outcome Measure Worksheet		
1A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from injury and illness caused by the physical environment.**	**Value**	**Calculat-ed O.M**
	(1)	Number of worker compensation claims filed for injuries that resulted from the physical environment in the past 12 months.	33	
	divided by	Average number of Full-Time Equivalent (FTE) staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1760	0
	(3)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	21,828	0
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	25	
	divided by	The average daily population in the past 12 months.	1760	0.01
	(5)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	25	
	divided by	The number of admissions in the past 12 months.	21,8.28	0.00
	(6)	Number of sanitation or health code violations identified by external agencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(7)	Number of health code violations corrected in the past 12 months.	0	
	divided by	The number of health code violations identified in the past 12 months.	0	0

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	(8)	Number of inmate grievances related to safety or sanitation found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate's grievances related to safety or sanitation in the past 12 months.	0	0
	(9)	Number of fire code violations corrected in the past 12 months.	0	
	divided by	The number of fire code violations cited by jurisdictional authority in the past 12 months.	0	0
	(10)	Number of inmate injuries resulting from fires requiring medical treatment in a 12-month period.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(11)	Number of inmate injuries (other than by fire) requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1760	0
	(12)	Number of staff injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of staff in the past 12 months.	(b)(7)(E)	0
	(13)	Number of staff injuries (other than fire) requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of staff in the past 12 months.	(b)(7)(E)	0
	(14)	Number of inmate lawsuits related to safety or sanitation found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate lawsuits related to safety or sanitation in the past 12 months.	0	0
1B		**Vehicles are maintained and operated in a manner that prevents harm to the community, staff, contractors, volunteers, and inmates.**		
	(1)	Number of vehicle accidents resulting in property damage in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1760	0.00
	(2)	Number of vehicle accidents resulting in injuries requiring medical treatment for any party in the past 12 months.	0	

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	divided by	The average daily population in the past 12 months.	1760	0
	(3)	Amount dollar of damage from vehicle accidents in the past 12 months.	106	
	divided by	The average daily population in the past 12 months.	1760	0.06
1C		**The number and severity of emergencies are minimized. When emergencies occur, the response minimizes the severity.**		
	(1)	Number of emergencies, caused by forces external to the facility, that result in property damage in the past 12 months.	0	
	divided by	The number emergencies.	0	0
	(2)	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(3)	Number of times that normal facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(4)	Number of hours that facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies caused by forces external to the facility.	0	0
	(5)	Number of emergencies that were not caused by forces external to the facility that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(6)	Number of injuries requiring medical attention that resulted from emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(7)	Number of times that normal facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	

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	divided by	The average daily population in the past 12 months.	1760	0
	(8)	Number of hours that facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies.	0	0
	(9)	Number of injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(10)	Number of fires that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(11)	Amount dollar of property damage from fire in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(12)	Number of code violations cited in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(13)	Number of incidents involving toxic or caustic materials in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(14)	Number of incidents of inventory discrepancies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
2A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from harm. Events that pose risk of harm are prevented. The number and severity of events are minimized.**	**Value**	**Calculat-ed O.M**
	(1)	Number of incidents involving harm in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(2)	Number of incidents in the past 12 months involving harm.	0	

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	divided by	The number of admissions in the past 12 months.	21,828	0
	(3)	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the incidents in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	21,828	0
	(5)	Number of unauthorized inmate absences from the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(6)	Number of instances of unauthorized access to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
2B		**Physical force is used only in instances of self-protection, protection of the inmate or others, prevention of property damage, or prevention of escape.**		
	(1)	Number of instances in which force was used in the past 12 months.	66	
	divided by	The average daily population in the past 12 months.	1760	0.03
	(2)	Number of instances in which force was used in the past 12 months.	66	
	divided by	The number of admissions in the past 12 months.	21,828	0.00
	(3)	Number of times that staff use of force were found to have been inappropriate in the past 12 months.	0	
	divided by	The number of instances in which force was used.	66	0
	(4)	Number of inmate grievances filed alleging inappropriate use of force in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(5)	Number of grievances alleging inappropriate use of force decided in favor of inmate in the past 12 months.	0	

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	divided by	The number of grievances alleging inappropriate use of force filed.	0	0
	(6)	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
2C		**Contraband is minimized. It is detected when present in the facility.**		
	(1)	Number of incidents involving contraband in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(2)	Number of incidents involving contraband in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	21,828	0
	(3)	Number of weapons found in the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(4)	Number of controlled substances found in the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(5)	Number of controlled substances found in the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	21,828	0
2D		**Improper access to and use of keys, tools and utensils are minimized.**		
	(1)	Number of incidents involving keys in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(2)	Number of incidents involving tools in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(3)	Number of incidents involving culinary equipment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0

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	(4)	Number of incidents involving medical equipment and sharps in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
3A		**Inmates comply with rules and regulations.**		
	(1)	Number of rule violations in the past 12 months.	741	
	divided by	The average daily population in the past 12 months.	1760	0.42
	(2)	Number of assaults—inmate against inmate, inmate against staff in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
4A		**Food service provides a nutritionally balanced diet. Food service operations are hygienic and sanitary.**		
	(1)	Number of documented inmate illnesses attributed to food service operations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(2)	Number of inmate grievances about food service decided in favor of the inmate the past 12 months.	10	
	divided by	The number of inmate grievances about food service in the past 12 months.	21	0.47
	(3)	Number of violations cited by independent authorities for food service sanitation in the past 12 months.	0	
		Divided by number of violations cited by independent authorities in the past 12 months.	0	0
4B		**Inmates maintain acceptable personal hygiene practices.**		
	(1)	Inmate grievances regarding inmate access to personal hygiene decided in favor of the inmate in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1760	0.00
	(2)	Number of inmate illnesses attributed to poor hygiene practices in the past 12 months.	4	
	divided by	The average daily population in the past 12 months.	1760	0.00

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	(3)	Number of inmates diagnosed with hygiene-related conditions (scabies, lice, or fungal infections) in the past 12 months.	4	
	divided by	The average daily population in the past 12 months.	1760	0.00
	(4)	Number of inmate grievances related to hygiene found in favor of the inmate in the past 12 months.	1	
	divided by	The number of inmate grievances related to hygiene in the past 12 months.	2	0.5
	(5)	Number of inmate lawsuits related to hygiene found in favor of the inmate in the past 12 months.	1	0
	divided by	The number of inmate lawsuits related to hygiene in the past 12 months.	0	0
4C		**Inmates maintain good health. Inmates have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner.**		
	(1)	Number of inmates with a positive tuberculin skin test in the past 12 months.	56	
	divided by	The number of admissions in the past 12 months.	21,828	0.00
	(2)	Number of inmates diagnosed with active tuberculosis in the past 12 months.	131	
	divided by	The average daily population in the past 12 months.	1760	0.07
	(3)	Number of conversions to a positive tuberculin skin test in the past 12 months.	56	
	divided by	The number of tuberculin skin tests given in the past 12 months.	56	0
	(4)	Number of inmates with a positive tuberculin skin test who completed prophylaxis treatment for tuberculosis in the past 12 months.	0	
	divided by	The number of inmates with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months.	0	0
	(5)	Number of Hepatitis C positive inmates in the past 12 months.	10	
	divided by	The average daily population in the past 12 months.	1760	0.00
	(6)	Number of HIV positive inmates in the past 12 months.	74	

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	divided by	The average daily population in the past 12 months.	1760	0.04
	(7)	Number of HIV positive inmates who are being treated with highly active antiretroviral treatment in the past 12 months.	74	
	divided by	The number of known HIV positive inmates in the past 12 months.	74	1
	(8)	Number of offenders with an individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time.	521	
	divided by	The average daily population in the past 12 months.	1760	0.29
	(9)	Number of inmate suicide attempts in the past 12 months.	11	
	divided by	The average daily population in the past 12 months.	1760	0
	(10)	Number of inmate suicides in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(11)	Number of inmate deaths due to homicide in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(12)	Number of inmate deaths due to injuries in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(13)	Number of medically expected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(14)	Number of medically unexpected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(15)	Number of inmate admissions to the infirmary (where available) in the past 12 months.	514	
	divided by	The average daily population in the past 12 months.	1760	0.29
	(16)	Number of inmate admissions to off-site hospitals in the past 12 months.	72	

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	divided by	The average daily population in the past 12 months.	1760	0.04
	(17)	Number of inmates transported off-site (via an ambulance or correctional vehicle) for treatment of emergency health conditions in the past 12 months.	321	
	divided by	The average daily population in the past 12 months.	1760	0.18
	(18)	Number of inmate specialty consults completed in the past 12 months.	2344	
	divided by	The number of specialty consults (on-site or off-site) ordered by primary health care provider (MD, NP, PA) in the past 12 months.	2344	1
	(19)	Number of inmate grievances about access to health care services found in favor of the inmate in the past 12 months.	11	
	divided by	The number of inmate grievances about access to healthcare services in the past 12 months.	100	0.11
	(20)	Number of inmate grievances related to the quality of health care found in favor of inmates in the past 12 months.	5	
	divided by	The number of inmate grievances related to the quality of health care in the past 12 months.	64	0.07
	(21)	Number of inmates' lawsuits about access to healthcare services found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate's lawsuits about access to healthcare services in the past 12 months.	0	0
	(22)	Number of individual sick call encounters in the past 12 months.	24,579	
	divided by	The average daily population in the past 12 months.	1760	13.96
	(23)	Number of physician visits contacts in the past 12 months.	13,245	
	divided by	The average daily population in the past 12 months.	1760	7.52
	(24)	Number of individualized dental treatment plans in the past 12 months.	1573	
	divided by	The average daily population in the past 12 months.	1760	0.89
	(25)	Number of hypertensive inmates enrolled in a chronic care clinic in the past 12 months.	643	
	divided by	The average daily population in the past 12 months.	1760	0.36

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	(26)	Number of diabetic inmates enrolled in a chronic care clinic in the past 12 months.	332	
	divided by	The average daily population in the past 12 months.	1760	0.18
	(27)	Number of incidents involving pharmaceuticals as contraband in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(28)	Number of cardiac diets received by inmates with cardiac disease in the past 12 months.	15	
	divided by	The number of cardiac diets prescribed in the past 12 months.	15	1
	(29)	Number of hypertensive diets received by inmates with hypertension in the past 12 months.	643	
	divided by	The number of hypertensive diets prescribed in the past 12 months.	643	1
	(30)	Number of diabetic diets received by inmates with diabetes in the past 12 months.	787	
	divided by	The number of diabetic diets prescribed in the past 12 months.	787	1
	(31)	Number of renal diets received by inmates with renal disease in the past 12 months.	11	
	divided by	The number of renal diets prescribed in the past 12 months.	11	1
	(32)	Number of needle-stick injuries in the past 12 months.	0	
	divided by	The number of employees on average in the past 12 months.	(b)(7)(E)	0
	(33)	Number of pharmacy dispensing errors in the past 12 months.	3	
	divided by	The number of prescriptions dispensed by the pharmacy in the past 12 months.	20,210	0.00
	(34)	Number of nursing medication administration errors in the past 12 months.	55	
	divided by	The number of medications administered in the past 12 months.	248,734	0.00
4D		**Health services are provided in a professionally acceptable manner. Staff are qualified, adequately trained, and demonstrate competency in their assigned duties.**		
	(1)	Number of staff with lapsed licensure and/or certification in the past 12 months.	0	

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	divided by	The number of licensed or certified staff in the past 12 months.	(b)(7)(E)	
	(2)	Number of new employees in the past 12 months who completed orientation training prior to undertaking job assignments.		
	divided by	The number of new employees in the past 12 months.		
	(3)	Number of employees completing in-service training requirements in the past 12 months.		
	divided by	The number of employees eligible in the past 12 months.		
	(4)	Number of MD staff who left employment in the past 12 months.		
	divided by	The number of authorized MD staff positions in the past 12 months.		
	(5)	Number of RN staff who left employment in the past 12 months.		
	divided by	The number of authorized RN staff positions in the past 12 months.		
	(6)	Number of LPN staff who left employment in the past 12 months.		
	divided by	The number of authorized LPN staff positions in the past 12 months.		
	(7)	Number of medical records staff who left employment in the past 12 months.		
	divided by	The number of medical records staff positions in the past 12 months.		
	(8)	Number of alleged sexual misconduct incidents between staff and detainees in the past 12 months.	4	
	divided by	Average daily population in the past 12 months.	1760	0.00
	(9)	Number of alleged sexual misconduct incidents between volunteers and/or contract personnel and detainees in the past 12 months.	1	
	divided by	Average daily population in the past 12 months.	1760	0
	(10)	Number of confirmed sexual misconduct incidents between staff and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1760	0
	(11)	Number of confirmed sexual misconduct incidents between volunteers and/or contact personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1760	0.00

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	(12)	Number of detainees identified as high risk with a history of sexually assaultive behavior in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1760	0
	(13)	Number of detainees identified as at risk for sexual victimization in the past 12 months.	30	
	divided by	Average daily population in the past 12 months.	1760	0.01
5A		**Inmates have opportunities to improve themselves while confined.**		
	(1)	Number of inmates who passed GED exams while confined in the past 12 months.	NA	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	NA	NA
	(2)	Total number of grade levels advanced by inmates in the past 12 months.	NA	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	NA	NA
	(3)	Number of certificates of vocational competency awarded to inmates in the past 12 months.	NA	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	NA	NA
5B		**Inmates maintain ties with their families and the community.**		
		NONE	NA	NA
5C		**The negative impact of confinement is reduced.**		
		NONE	NA	NA
6A		**Inmates' rights are not violated.**		
	(1)	Total number of inmate grievances in the past 12 months, regarding: (a) access to court; (b) mail or correspondence; (c) sexual harassment; (d) discipline; (e) discrimination; (f) protection from harm.	34	
	divided by	The average daily population in the past 12 months.	1760	0.01
	(2)	Number of inmate grievances (see [a] through [e] above) decided in favor of inmates in the past 12 months.	8	
	divided by	The total number of grievances filed in the past 12 months.	179	0.04

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	(3)	Total number of inmate court suits alleging violation of inmate rights filed against the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(4)	Number of inmate court suits alleging violation of inmate rights decided in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate suits filed in the past 12 months.	0	0
6B		**Inmates are treated fairly.**		
	(1)	Number of inmate grievances regarding discrimination in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1760	0.00
	(2)	Number of inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months.	1	
	divided by	The total number of inmate grievances filed regarding discrimination in the past 12 months.	1	1
	(3)	Number of grievances resolved in favor of inmates in the past 12 months.	58	
	divided by	The average daily population in the past 12 months.	1760	0.03
	(4)	Number of grievances resolved in favor of inmates in the past 12 months.	58	
	divided by	The total number of inmate grievances filed in the past 12 months.	151	0.38
	(5)	Number of court malpractice or torte liability cases found in favor of the inmate in the past 12 months.	0	
	divided by	The number of court malpractice or torte liability cases in the past 12 months.	0	0
6C		**Alleged rule violations are handled in a manner that provides inmates with appropriate procedural safeguards.**		
	(1)	Number of disciplinary incidents resolved informally in the past 12 months.	35	
	divided by	The average daily population in the past 12 months.	1760	0.01
	(2)	Number of formal inmate disciplinary decisions that were appealed in the past 12 months.	30	
	divided by	The total number of disciplinary decisions made in the past 12 months.	741	0.04

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	(3)	Number of appealed disciplinary decisions decided in favor of the inmate in the past 12 months.	8	
	divided by	The total number of disciplinary decisions made in the past 12 months.	741	0.01
	(4)	Number of grievances filed by inmates challenging disciplinary procedures in the past 12 months.	29	
	divided by	The average daily population in the past 12 months.	1760	0.01
	(5)	Number of disciplinary-related grievances resolved in favor of the inmate in the past 12 months.	8	
	divided by	The total number of disciplinary-related grievances filed in the past 12 months.	29	0.27
	(6)	Number of court suits filed against the facility regarding discipline in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
	(7)	Number of court cases regarding discipline decided against the facility in the past 12 months.	0	
	divided by	The total number of court decisions regarding discipline decided in the past 12 months.	0	0
	(8)	Number of rule violations in the past 12 months.	741	
	divided by	The average daily population in the past 12 months.	1760	0.42
	(9)	Number of inmates terminated from the facility due to rule violations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1760	0
6D		**Inmates take responsibility for their actions.**		
	(1)	Number of inmates released in the past 12 months who made regular payments toward their restitution obligations.	NA	
	divided by	The number of inmates who had restitution obligations in the past 12 months.	NA	NA
	(2)	Number of inmates who satisfy their court cost/fines obligations in the past 12 months.	NA	
	divided by	The number of inmates who had court cost/fine obligations in the past 12 months.	NA	NA
	(3)	Total amount of restitution paid by inmates in the past 12 months.	NA	

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	divided by	The average daily population in the past 12 months.	NA	NA
	(4)	Total number of hours of community service donated by inmates in the past 12 months.	NA	
	divided by	The average daily population in the past 12 months.	NA	NA
	(5)	Total number of inmates who participated in restitution in the past 12 months.	NA	
	divided by	The total number of inmates housed in the past 12 months.	NA	NA
	(6)	Total number of inmates who participated in community service work in the past 12 months.	NA	
	divided by	The total number of inmates housed in the past 12 months.	NA	NA
	(7)	Total number of inmates who participated in victim awareness programs in the past 12 months.	NA	
	divided by	The total number of inmates housed in the past 12 months.	NA	NA
	(8)	Total amount of restitution paid by inmates in the past 12 months.	NA	
	divided by	The total number of inmates housed in the past 12 months	NA	NA
	(9)	Total number of hours delivered by inmates who participated in community service work in the past 12 months.	NA	
	divided by	The total number of inmates housed in the past 12 months.	NA	NA
7A		**The facility operates as a legal entity.**		
		NONE	NA	NA
7B		**Staff, contractors, and volunteers demonstrate competency in their assigned duties.**		
	(1)	Total number of years of staff members' education as of the end of the last calendar year.	(b)(7)(E)	
	divided by	The number of staff at the end of the last calendar year.		
	(2)	Number of staff who left employment for any reason in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
	(3)	Total number of credit hours in course relevant to their facility responsibilities earned by staff participating in higher education in the past 12 months.		

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	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(4)	Number of professional development events attended by staff in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
7C		**Staff, contractors, and volunteers are professional, ethical and accountable.**		
	(1)	Number of incidents in which staff was found to have acted in violation of facility policy in the past 12 months.	88	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of staff terminated for conduct violations in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
	(3)	Number of inmate grievances attributed to improper staff conducts which were upheld in the past 12 months.	23	
	divided by	The number of inmate grievances alleging improper staff conduct filed in the past 12 months.	55	0.41
	(4)	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months.	23	
	divided by	The average daily population for the past 12 months.	1760	0.01
	(5)	Where staff is tested, the number of staff substance abuse tests failed in the past 12 months.	2	
	divided by	The number of staff substance abuse tests administered in the past 12 months.	100	0.02
	(6)	Number of staff terminations for violation of drug-free work policy in the past 12 months.	(b)(7)(E)	
	divided by	The number of staff terminations in the past 12 months.		
	(7)	The average number of physicians employed in the past 12 months.		
	divided by	The number of physician positions authorized in the past 12 months.		
	(8)	The average number of nurses employed in the past 12 months.		
	divided by	The number of nurse positions authorized in the past 12 months.		

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	(9)	The average number of mid-level health care practitioners employed in the past 12 months.	(b)(7)(E)	
	divided by	The number of mid-level health care practitioner positions authorized in the past 12 months.		
	(10)	The average number of ancillary health care staff employed in the past 12 months.		
	divided by	The number of ancillary health care staff positions authorized in the past 12 months.		
7D		**The facility is administered efficiently and responsibly.**		
	(1)	Net amount of budget shortfalls or surplus at the end of the last fiscal year (budget less expenditures).	NA	
	divided by	The budget for the past 12 months.	NA	Proprietary
	(2)	Number of material audit findings by an independent financial auditor at the conclusion of the last audit.	0	
		NONE		NA
	(3)	Number of grievances filed by inmates regarding their records or property in the past 12 months.	21	
	divided by	The average daily population in the past 12 months.	1760	0.01
	(4)	Number of inmate grievances (records/property) decided in favor of inmates in the past 12 months.	10	
	divided by	The total number of inmate grievances (records/property) in the past 12 months.	21	0.47
	(5)	Number of objectives achieved in the past 12 months.	57	
	divided by	The number of objectives for the past 12 months.	65	
	(6)	Number of program changes made in the past 12 months.	1	
	divided by	The number of program changes recommended in the past 12 months.	0	0
	(7)	Number of problems identified by internal health care review that were corrected in the past 12 months.	3	
	divided by	The number of problems identified by internal health care review in the past 12 months.	3	1
7E		**Staff are treated fairly.**		
	(1)	Number of grievances filed by staff in the past 12 months.	24	

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	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of staff grievances decided in favor of staff in the past 12 months.	0	
	divided by	The total number of staff grievances in the past 12 months.	24	0
	(3)	Total number of years of staff members' experience in the field as of the end of the last calendar year.	2506	
	divided by	The number of staff at the end of the last calendar year (e.g. average number of years' experience).	(b)(7)(E)	
	(4)	Number of staff termination or demotion hearings in which the facility decision was upheld in the past 12 months.	0	
	divided by	The number of staff termination or demotion hearings requested in the past 12 months.	0	0
7F		**The facility is a responsible member of the community.**		
	(1)	Total number of hours of volunteer service delivered by members of the community in the past 12 months.	480	
	divided by	The average daily population of inmates in the past 12 months.	1760	0.27
	(2)	Total number of individual community members who provided voluntary service in the past 12 months.	19	
	divided by	The average daily population of inmates in the past 12 months.	1760	0.01
	(3)	Total number of complaints filed by media regarding access to information in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1760	0
	(4)	Total number of positive statements made by media regarding the facility in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1760	0
	(5)	Total number of complaints from the community in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1760	0

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	(6)	Total number of hours of community service work delivered by inmates in the past 12 months.	NA	NA
	divided by	The average daily population of inmates in the past 12 months.	1760	0

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

ICE Health Service Corps (IHSC)
LaSalle Detention Facility (IHSC)
Jena, Louisiana

November 13-14, 2017

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C) Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The audit of the LaSalle Detention Facility (IHSC), Jena, Louisiana was conducted on November 13-14, 2017 utilizing the American Correctional Association (ACA) Standards for Performance Based, Health Care for Adult Correctional Institution, 1st Edition and the 2014 Standards Supplement. The following team conducted the audit: (b)(6); (b)(7)(C) Chairperson and (b)(6); (b)(7)(C) Team Member. The facility reaccreditation audit was simultaneously audited by (b)(6); (b)(7)(C) ALDF-Chairperson, and (b)(6); (b)(7)(C) ALDF-Team Member.

B. Facility Demographics

Rated Capacity: 1328 (Males - 1096 and Females - 232)
Actual Population: 1008 (Males - 875 and Females - 133) as of 11/13/2017
Average Daily Population for the last 12 months: 1123
Average Length of Stay: 16 days
Security/Custody Level:

- ✓ Maximum (Red) - 227
- ✓ Medium (Orange) - 243
- ✓ Medium Low (Yellow) - 101
- ✓ Minimum (Blue) - 437

Age Range of Detainees: 18-74
Gender: Male/Female

(b)(7)(E)

C. Facility Description

The LaSalle Detention Facility (LDF) provides detention services, housing, and transportation for detainees who are in administrative custody of the Immigration and Customs Enforcement (ICE) Department of Homeland Security. The LDF is privately owned and operated by the GEO Group under a contract with the Department of Homeland Security. Medical services are provided by the Immigration Health Service Corporation (IHSC).The facility houses individuals, both male and female, who are pending immigration review.

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The facility mission is to provide the highest level of service and safety to the client, and to ensure the safety of the community, staff, and detainees in custody. The facility is physically located at 830 Pineville Road, Jena, Louisiana. The facility was constructed in 1998. An Intergovernmental Service Agreement was awarded in July of 2007 with the US Customs Enforcement allowing the LDF to provide secure detention services to male and female detainees. The facility has been operated by the GEO Group with health care services provided by IHSC since that time.

(b)(7)(E)

(b)(7)(E) There is visiting area for both contact and non-contact visiting. There are 17 housings units, including a male and female segregation pod. All general housings are open bay style. There are five medical examination rooms/nursing stations to service the units. There is an intake booking area with two medical rooms. Dorm style pods have group showers, sinks, and toilets.

During FY17, the LDF transported and processed 37,944 detainees for removal and/or deportation. GTI, the transportation division, has travelled 501,697 miles to date. Also, this FY17, the LDF underwent successful audits by the GEO Eastern Regional Office for the annual Quality Compliance Process (QCP) process and the annual audit of the Performance Based National Detention Standards. LDF passed the client mandated Sexual Abuse and Assault Prevention Intervention (SAAPI) audit with no corrective actions needed. LDF utilizes language line translation.

ICE Health Services Corps Mission Statement -"IHSC is committed to providing health care services to reduce global disease and support the safe apprehension, enforcement and removal of detained individuals involved in immigration proceedings".

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(b)(7)(E)

D. Pre-Audit Meeting

On Sunday, November 12, 2017 the members of the audit team were transported from the Alexandria International Airport, Alexandria, Louisiana to the Holiday Inn Express & Suites, Pineville, Louisiana by (b)(6); (b)(7)(C) Assistant Warden of Finance and Administration (AWFA).The distance from the airport to the hotel was approximately 15 miles.

The audit team met at the hotel on that evening to discuss the information provided by the Association staff and the officials from the LaSalle Detention Facility (IHSC).

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The chairperson divided the standards into the following groups:

Standards #HC 1A-01 to 3A-11 to (b)(6); (b)(7)(C)
Standards #HC 3A-12 to 7C-03 to

The audit team members attended an "ice-breaker" dinner at the Johnny Carinos restaurant approximately from 06:00 PM to 08:15 PM that evening with Warden David Cole, (b)(6); (b)(7)(C) GEO Corporate Accreditation Manager, ACA-ALDF audit team and 13 other LaSalle Detention Facility employees. General conversation followed as the team member and the facility staff became acquainted, and general audit goals and procedures for the audit were discussed.

E. The Audit Process

1. Transportation

On Monday, November 13, 2017, the audit teams (IHSC and ALDF) were picked up from the hotel by (b)(6); (b)(7)(C) GEO Corporate Accreditation Manager at 07:12 AM and arriving LDF at 07:58 AM. The team followed the LDF's security procedures and was escorted to the facility by (b)(6); (b)(7)(C) GEO Corporate Accreditation Manager for a brief housekeeping meeting with the David Cole, Facility Warden and the Health Services Administrator, CDR (b)(6); (b)(7)(C) The team expressed the appreciation of the Association for the opportunity to be involved with LaSalle Detention Facility in the accreditation process. The ACA-ALDF audit team participated in this pre-entrance meeting. The meeting lasted from 08:05 AM to 08:25 AM.

2. Entrance Interview

At 8:27 AM the same day, the audit team proceeded with the formal joint (IHSC and ALDF) entrance meeting at the main conference room. The audit schedule and procedures were discussed, and the staffs were asked about any problem areas of which the teams should be aware. The staffs were advised that the audit team would meet with them each evening prior to their departure from the facility to discuss the progress of the audit up to that point, and any problems that were encountered, and the audit team will attempt to review all the mandatory standards on the first day. Escorts were requested to accompany the auditors on the tour and subsequent visits to departments, and to note the number of detainees and the names and titles of employees with whom the auditors spoke. The staffs were asked if any detainee or employee had requested to speak with the auditors. No requests had been made. The audit Chairpersons expressed the team's appreciation and the appreciation of the ACA for the opportunity to be involved with the audits in its re-accreditation process, and emphasized the goals of the accreditation, which are to improve the efficiency and effectiveness of correctional systems throughout the United States.

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The audit teams were aware that the staffs had worked long and hard in preparation for this event, and accordingly the teams would endeavor to provide a fair, equitable and thorough audit as possible while holding them accountable to high standards. The team members would visit as many departments and areas as possible relating to the audit and meet and speak with as many staffs and detainees as possible in the time available, while at the same time strive to be as non-intrusive as possible. It was requested that when audit team members paused to speak with detainees, that staffs step away so that the conversation may remain private and the team would like to observe the practice in any medical emergency. The audit team reemphasized that the purpose of the audit is to be helpful and to assist the facility in achieving its re-accreditation. The entrance meeting lasted until 08:40 AM.

The following persons were in attendance:

David Cole	Warden
(b)(6); (b)(7)(C)	GEO Corporate Accreditation Manager
	Assistant Warden of Security Operations
	Assistant Warden of Finance and Administration
	Chief of Security
	Food Service Manager
	Executive Secretary
	Maintenance Supervisor
	Transportation Manager
	Human Resources Manager
	Classification Manager
	Captain
	Fire and Safety Manager
	PREA Compliance Manager
	Compliance Administrator
	Training Manager
	Medical Director (IHSC)
	Health Services Administrator (IHSC)
	Registered Nurse (IHSC)
	ACA-ALDF Audit Chairperson
	ACA-ALDF Audit Team Member

3. Facility Tour

The IHSC team toured the medical area and other areas relating to the IHSC audit from 08:50 AM to 10:51 AM. ACA audit notices were posted throughout the facility. Staff and detainees were aware that an audit was taking place. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

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(b)(6); (b)(7)(C)	Health Services Administrator (IHSC) Registered Nurse Warden Compliance Administrator PREA Compliance Manager Fire and Safety Manager Maintenance Supervisor Chief of Security GEO Corporate Accreditation Manager Assistant Warden of Security Operations Assistant Warden of Finance and Administration

The following areas of the institution were visited and the following personnel and detainees were encountered during the course of the tour:

Intake	(b)(6); (b)(7)(C)
Food Service	
Laundry Service	
Commissary/Canteen	
Medical	
Security-Owl Alpha Unit	
Security-Owl Bravo Unit	
Security-Owl Charlie Unit	

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Security-Owl Delta Unit
Security-Owl Rover Unit
Security-Falcon Alpha Unit

Security-Falcon Bravo Unit
Security-Falcon Charlie Unit
Central Control

(b)(6); (b)(7)(C)

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life. The facility noise levels are noteworthy. There was no offensive order or smell of fresh paint. There was no evidence of pest or rodent infestation or complaint. All areas of the facility are clean and well maintained. Chemicals are properly stored and well controlled. MSDS sheets are available. Tools are on shadow boards and appropriately stored and inventoried. The housing units are clean with the detainee living areas being neat and organized. There is a large outdoor exercise area with a soccer field, fixed weights, and basketball hoops. Each housing unit has a day room equipped with a television, board games, puzzles and a microwave. The housing units were quiet and there appeared to be a very low level of tension in the units.

Food Service:

Food Service is provided by staff working for GEO. The food service area is clean. The area is inspected weekly by food service staff, monthly by the safety officer and annually be the health department. A six week cycle menu, approved annually by a Registered Dietitian, is utilized and based on two hot/one cold meals per day. A diet for health, hyper calorie diet, renal diet, vegetarian and texture modifications are available. LDF practices satellite feeding in the units. The audit team observed trays and sampled one lunch meal of mash potato w/gravy, country fried steak, biscuit, mixed salad w/dressing and Kool-Aid drink on the second day of the audit. The meal was nutritionally adequate, palatable and temperature tested. The cost per meal was $1.05. There is no pork products served. Medical diets are provided by the food service department upon receipt of written instructions from the facility Clinical Director. Meals samples are kept for 72 hours. At the time of the audit, there were 111 medical diets. These diet orders contain both start and stop dates. These may be ordered anywhere from one day to length of stay. Medical evaluations and screenings are done on detainee workers which monitored cuts/sores, burns, runny nose, nail condition and cold/flu symptoms.

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Detainees are not allowed to handle food preparation. Refrigerators, freezers and the dry storage area are clean, orderly and clutter-free, and temperatures are in the appropriate ranges. The dishwasher was in proper working order, and documentation reflected temperatures in the appropriate range.

Medical Care:

Medical services at the LaSalle Detention Facility (LDF) are contracted through the INGENESIS. They also utilize Public Health Service (PHS), STG International and Akahi contract staffing. They provide medical, mental health and dental services. LDF medical receives transfers and in-transit detainees and some with the history of high-risk behaviors, compounded by lack of medical care and /or mental health treatment, and are more likely to have chronic illnesses and infectious diseases. The facility has a responsible physician (MD) and a Health Services Administrator (HSA). The working relationship between medical, mental health, program, dental and security are very remarkable. Medical staffs are well trained and caring professionals. The team interviewed the youngest female (18 years) and the oldest male (74 years) detainees; they are complimentary of medical services. Telehealth is practiced at the LDF. Other accreditation for the LDF includes National Commission on Correctional Health Care (NCCHC), 11/2017 and Performance Based National Detention Standards (PBNDS), 9/2017 (ICE). All detainees receive initial screening up arrival, and physical exam within 14 days of arrival.

LDF medical operates three shifts (b)(7)(E)

(b)(7)(E)

Director (MD). The audit team observed shift changes on first and second day of the audit and found the process structured. The LDF medical has five examination rooms plus five nursing stations (one each in the unit).The waiting rooms have access to water, bathrooms, education materials and health pamphlets. Telemedicine is not available at the LDF. New fulltime employees receive in-service trainings and OJT trainings. Staffing, space and radios for communication continues to be an issue.

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LDF medical has the followings:

- ✓ 2 AED's (secured and inspected)
- ✓ 2 EKG's (secured and inspected, and read on site)
- ✓ 1 Fixed digital chest x-ray machine
- ✓ 2 Emergency bags (secured, inspected and sealed)
- ✓ 2 Medical crash carts (secured, inspected and sealed)
- ✓ 1 Emergency stretcher with straps (secured and inspected)
- ✓ 1 Transport Gurney (secured and inspected)
- ✓ 1 Secure medication room
- ✓ 1 Refrigerator (Flu, TB Solutions, etc.)
- ✓ 1 Refrigerator (Specimen)
- ✓ 8 Portable oxygen cylinders (secured and inspected by Cookies DME)
- ✓ I Oxygen concentrator (secured and inspected by Cookies DME)
- ✓ 4 Negative pressure rooms (cameras, toilets and sinks, and inspected)
- ✓ 2 Suicide observation rooms (cameras, toilets and sinks)

LDF has a Disability Placement Program (DPP) that provides for housing accessible lockers, bunk beds with grabs bars, accessible TTY phones, volume control phones, accessible dayroom tables and accessible path of travel. There are ample supplies of walking sticks, crutches and wheel chairs in the facility. There is a language line translation available.

LDF uses the following hospitals for inpatient hospitalization:

1. LaSalle General Hospital, Jena, Louisiana (ER)
2. Rapides Regional Medical Center, Alexandria, Louisiana
3. St. Francis Cabrini Hospital, Alexandria, Louisiana
4. Louisiana State University Medical Center, New Orleans, Louisiana

LDF has an agreement with the Jena Fire Department (5 miles, 5 minutes), and LaSalle Parish (3.2 miles) and LaSalle General Hospital (1.4 miles) for ambulance services in case of medical emergencies. Non-emergent medical transportation is done by facility staff to either a hospital facility or community provider for offsite consultations. The nurses have Basic Life Support (BLS) certified through the American Heart Association (AHA). Medical maintain basic TTA protocol medicines. The Master SDS is maintained in medical. Officers are trained on first aid, CPR and AED, and are considered first responders. Upon admittance to the LDF, detainees receive a detainee handbook to aid in adjustment to detention setting. This documentation contains information regarding medical services, sick call process, grievance procedures and hygiene rules. Other methods are used to inform detainees about MRSA, AIDS, Hepatitis, and the spread of HIV, blood borne pathogens and safety.

AMERICAN OVERSIGHT

Sick call is provided three times a day and 7 days/week in General Population (GP) and Special Management Unit (SMU) at 06:00 AM, 09:00 AM, 06:00 PM and as needed. Detainees sign up for sick calls at each housing unit between the hours of 05:00 AM and 06: 00 AM. Detainees housed in SMU access all medical services via face to face encounters with an RN during daily rounds. Detainees housed in GP access all medical services via call out logs. The average monthly sick calls are 455. The audit team observed sick call process in GP and SMU on the second day of the audit and found the process well organized. Medical requests are triaged within 3-4 days, and any patient with symptoms is seen within one day. There is no medical copay. No detainee is denied health care service. LDF uses detainee electronic medical records. Medical grievance is through the grievance box, collected by a grievance coordinator, and reviewed by the HSA within 2 days. LDF averages three substantiated medical grievances per year mostly on medication preference, medication refills and time line to see a provider. Specialty services/consults are provided through off-site contracted specialists. The turnaround time is 72 hours. Optometry service is contracted off-site. There were three pregnant detainees at the time of the audit. All pregnant females are referred to an offsite OB-GYN specialist. The number of chronic care detainees excluding mental health at the time of the audit was 158.

LDF has a plan for the management of communicable diseases including education on prevention, diagnosis, treatment and isolation. LDF has an infectious disease coordinator. LDF has four single-bed negative pressure rooms with to date inspections and a medical housing unit. Infirmary service is provided through a contracted hospital. MRSA precautions are in place. Universal precautions are practiced throughout the facility. There are available first aid and blood borne pathogen kits. There are eye wash stations present in appropriate areas. Hand sanitizers (non-alcohol) dispensers were located throughout medical and other areas. Sanitation and housekeeping is provided through a contractor-Jani King. The total monthly TB tests are 5. An annual TB screening is conducted on all detainees after 12 months. Initial medical screening is done while the detainees are on the transfer bus. LDF offers limited TB sticks, mostly chest x-rays on site.

Medications are stored in medication rooms and secured behind double locks. A nurse administers medications including diabetic lines four times a day and seven days a week in GP and SMU at 09:00 AM, 01:00 PM, 04:30 PM, 09:00 PM and as needed. Prior to giving medications, detainee's identification is confirmed and mouth cavities checked after administration. The audit team observed medication administrations in the GP and SMU on the second day of the audit and found the process organized and timely. All no shows or refusal to medications are documented and /or referred. The HSA checks the MARS paper record for missed doses. Medical diets are coordinated with the food service. The audit team examined the manual during the audit and found it current. The manual is updated regularly by medical. There are 111 medical diets, including 51 diabetics (36-insulin and 15-non insulin dependents) at the time of the audit. Some insulin dependent diabetics receive midnight snacks.

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The average monthly detainees on prescription medications are 557, and controlled medications are 11. Some medications are crushed per doctor's order. Detainees are provided script medications upon release depending on illness; 15 days-normal, 22 days-TB and 38 days-HIV. Specific over-the-counter (OTC) medications are offered at the Commissary, and reviewed and approved by the Clinical Director (MD).

LDF has a dispensary, and supported by (b)(7)(E) (b)(7)(E) LDF maintain stock order medications. Medications are ordered through the Cardinal Pharmacy. The backup pharmacy is the local Jena Pharmacy. Detainees are allowed keep-on-person (KOP) medications. The pharmacy is audited by the Pharmacist monthly and the HSA quarterly. A random inventory count on sharps and controlled medications was accurate. The pharmacy has a refrigerator for the storage of insulin, vaccines and ice packs. The audit team found the temperature log and inventory current. Basic medical supplies and materials are obtained through McKesson. The disposal of expired, unused, discontinued, recalled, over stocked medications including prescription, (pills and liquids) and narcotics are arranged through the Reverse Distributor-Pharma logistics. At the time of the audit there were some medications awaiting disposal. Records are maintained on disposal process.

LDF medical has a draw only lab. Specimens are collected on site. Blood is spun and sent out for analysis to the LabCorp 5–days/week and reports received through fax/phone within 24-48 hours. STAT labs are sent to the LaSalle General Hospital and results received through fax/phone within 2-4 hours. Average monthly detainee lab tests are 230. Stericycle is contracted to pick up the biohazard and sharps wastes. The audit team checked the specimen refrigerator temperature log and found the records current. Chronic care patients receive annual screening test. Laboratory results are also incorporated into the EMR. Digital radiology is used in the facility with hard copy over-reads scanned into the electronic health record (EMR). LDF has a fixed wall stand digital chest x-ray machine. The X-ray department is supported by two fulltime contracted Radiologic Technologists. Radiology services (MRI, Ultrasound, etc.), including STATS are provided through the LaSalle General Hospital with results received within hours by phone/fax depending on level of acuity.

LDF performs detoxification from alcohol, opiates hypnotics, other stimulants and sedative hypnotic drugs. Substance abuse treatment is provided, as are a large number of behavioral health groups and classes. All detainees enrolled and participating in these groups had individual treatment plans in place. There are regularly scheduled multi-disciplinary team meetings, including medication management when appropriate and necessary.

(b)(7)(E)

Dental services are provided from 07:30 AM - 04:00 PM (Monday-Friday).

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Dental services include basic dentistry, prophylaxis, fillings, partials, extractions, cleaning, oral cancer screenings and patient education. The detainees access dental health services through the sick call process. The audit team reviewed the licenses, registrations, records and random inventory of sharps and instruments and found them accurate. The dental area is clean. Dental instruments and sharps not used at the year of expiration are re-autoclaved and repackaged. Dental spore test is through SPC Medical. The Dentist has a standing order; dental emergency outside the expertise of the nurse is referred to one of the contracted hospitals. The Dentist is notified. Dental at LDF is equipped with one (1) digital dental bitewing x-ray machine, one (1) dental chair and one (1) Panorex digital x-ray machine. The dental wait time is less than 7 days. Urgent requests are seen within 24 hrs. The average monthly dental appointment is 160. Dental amalgam disposal is through the Wastewise. Dosimeter reading is through Landauer Dosimetry. Dental chair traps are cleaned weekly. Dental supplies and equipment service, including dental compressor service are obtained through the Henry Schein.

Mental health is supported by (b)(7)(E) (b)(7)(E) They provide services 24/7. Daily rounds are conducted. Detainees access mental health services via the sick call process. Staffs can refer services. There are approximately 262 detainees seen monthly. All suicide ideations are referred to mental health and monitored, and are observed 1:1. Mental health utilizes the two single-bed isolation rooms. There are available suicide smocks and blankets. Tele-psychiatry is practiced at LDF. LDF maintains zero tolerance for sexual abuse and harassment. Detainees are provided information on enhanced victim services and rape crisis hotline. Rounds are done daily and are evaluated every 30/60/90 days depending on needs. Program services include crisis intervention, individual and group counseling and medication management. LDF has no therapeutic community program. Severely developmentally and disabled detainees receive a mental health evaluation where appropriate and are referred for placement at the following inpatient hospitals:

1. Columbia Regional Care Center, Columbia, South Carolina
2. Krome Transitional Unit (KTU), Miami, FL

There were approximately 25 detainees on psychotropic medication at the time of the audit.

Laundry:

Laundry services are centralized. Laundry has six commercial washers (capacity ranging from 75-130 lbs. each) and four commercial dryers (capacity ranging from 130-170 lbs. each). Dryer lint filters are cleaned after each use. The audit team observed adequate supply of bed linens, pillows and blankets. Laundry process is done using mess bags. Detainees are issued three sets of clothing upon admission. Linens are exchanged twice per week, blankets once per month and clothing twice per week.

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Medical has adequate supplies of linens and clothing to support medical housing. Medical wastes are contained and washed separately using biohazard dissolving bags.

F. Examination of Records

Following the facility tour, the team proceeded to a medical private office to review the accreditation paper files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

   The facility had no consent decrees, class action lawsuits or adverse judgments in the past year according to records.

2. Significant Incidents/Health Care Outcome Measures

   Significant Incident Summary:

   During the audit period Oct 2016 through September 2017, the number of detainee-on-detainee assaults was 8.While the number is noteworthy and will impact health care services, it was determined that it was within the appropriate range that would be expected for an institution of this size, custody level and mission.

   Health Care Outcome Measures:

   The audit team reviewed the health care outcome measures with the health care administrative team. The values stated for the measures reflected a very busy facility with high transfer of detainees from diverse population and age, with a wide variety of health concerns. The audit team concurs with the measures.

3. Departmental Visits

   The team revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Food Service	(b)(6); (b)(7)(C)
Medical	

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(b)(6); (b)(7)(C)

4. Shifts

a. Day and Evening Shifts

The team was present at the facility from 07:58 AM to 04:30 PM on the first day of the audit. The team observed evening shift briefing at 03:00 PM. The briefing was mutual and participatory. The team briefly introduced themselves and discussed the purpose of the audit and matters pertaining to the audit. The team observed medication administration while the rest of the medical staff was busy taking care of the detainees and are pleasant and professional. (b)(6); (b)(7)(C) Health Services Administrator, (b)(6); (b)(7)(C) Pharmacist, (b)(6); (b)(7)(C) Psychiatrist, (b)(6); (b)(7)(C) Nurse Manager, (b)(6); (b)(7)(C) Clinical Pharmacist, (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Licensed Clinical Social Worker and (b)(7)(E) other medical staffs was present.

b. Night Shift

The team was present at the facility during the night shift at 05:30 AM on the second day of the audit and spoke the incoming and outgoing shifts. The audit team observed the shift change and morning briefing. Shift briefings are a normal occurrence. The shift supervisors passed on information to the oncoming shift. A familiar and easy rapport was evident among the staff, and information was freely exchanged. (b)(6); (b)(7)(C) Health Services Administrator, (b)(6); (b)(7)(C) Nurse Manager, (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Clinical Pharmacist was present.

5. Status of Previously Non-compliant Standards/Plans of Action

There were no standards previously found non-compliant.

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

There were no standards previously found non-compliant or granted a waiver.

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G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Detainee Interviews

The audit team interviewed and spoke to approximately 89 detainees (males and females) including the oldest and youngest of the male and female who stated that they generally felt secure at the facility and were treated fairly by staff. Their basic needs were being met and they felt that they were making positive progress towards eventual and successful release. They also felt that their basic medical needs were being met. They have ready access to sick call process and all were aware of the grievance process. Detainee morale appeared to be good and they were cooperative, respectful and were aware of the audit, and participated in the preparation for the audit. Notices of the ACA Accreditation process were observed to have been posted at different locations readily available to the detainees. A few of the detainees requested to speak privately with the auditors regarding A/C issues in Owl-Delta Unit, and management was addressing the matter. The three pregnant females that were interviewed requested consistency in receiving extra snacks and requested additional blankets, and management was addressing the matter at the time of the audit.

2. Staff Interviews

The audit team interviewed and spoke to approximately 45 employees, excluding 27 medical staffs, and observed them in the performance of their duties. The audit team observed structured medical shift change briefings. Staffs were polite, cooperative, and conducted themselves in a professional manner. There was a normal working relationship between medical, dental, mental health, programs and security, and communication flowed freely. Gender and ethnic diversity was good and morale also appeared to be good. Staff indicated that their training were excellent and are applicable to their positions and job needs.

H. Exit Discussion

The exit interview was held independent of the ALDF audit at 11:36 AM in the medical conference/dining room with the CDR Dan Fletcher, Health Services Administrator, the facility Warden, LCDR (b)(6); (b)(7)(C) HSA, (b)(6); (b)(7)(C) Facility and twenty-six (26) IHSC staffs.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

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The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive to maintain their high level of professionalism in the correctional field.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Performance Based Health Care for Adult Correctional Institution, 1st Edition	
Supplement	2014 Standards Supplement	
Facility/Program	LaSalle Detention Facility (IHSC)	
Audit Dates	November 13-14, 2017	
Auditor(s)	(b)(6); (b)(7)(C) Audit Chairperson (b)(6); (b)(7)(C) Audit Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	44	91
Number Not Applicable	0	9
Number Applicable	44	82
Number Non-Compliance	0	0
Number in Compliance	44	82
Percentage (%) of Compliance	100%	100%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

ICE Health Service Corps (IHSC)
LaSalle Detention Facility (IHSC)
Jena, Louisiana

November 13-14, 2017

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #1-HC-1A-02

WHEN MEDICAL COPAYMENT FEES ARE IMPOSED, THE PROGRAM ENSURES THAT, AT A MINIMUM, THE FOLLOWING ARE OBSERVED:

- ✓ ALL OFFENDERS ARE ADVISED, IN WRITING, AT THE TIME OF ADMISSION TO THE FACILITY OF THE GUIDELINES OF THE COPAYMENT PROGRAM.
- ✓ NEEDED OFFENDER HEALTH CARE IS NOT DENIED DUE TO LACK OF AVAILABLE FUNDS.
- ✓ COPAYMENT FEES SHALL BE WAVED WHEN APPOINTMENTS OR SERVICES, INCLUDING FOLLOW-UP APPOINTMENTS, ARE INITIATED BY MEDICAL STAFF.

FINDINGS:

LDF does not charge detainees copay for any medical services to include pharmaceuticals dispensed by medical personnel.

Standard #1-HC-2A-04 REVISED JANUARY 2006 (REF. 4-4383)

WHEN INSTITUTIONS DO NOT HAVE QUALIFIED HEALTH CARE STAFF, HEALTH TRAINED PERSONNEL COORDINATE THE HEALTH DELIVERY SERVICES IN THE INSTITUTION UNDER THE JOINT SUPERVISION OF THE RESPONSIBLE HEALTH AUTHORITY AND WARDEN OR SUPERINTENDENT

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FINDINGS:

LDF has a qualified health care staff to coordinate the health delivery services.

Standard #1-HC-2A-16

IF VOLUNTEERS ARE UTILIZED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTION, TRAINING, STAFF SUPERVISON, FACILITY ORIENTATION, AND DEFINITION OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITYVOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAINING VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION

FINDINGS:

LDF does not use volunteers in the delivery of health care.

Standard #1-HC-2A-17

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION, COMMENSURATE WITH THEIR LEVEL OF TRAINING THERE IS A WRITTEN AGREEMENT BETWEEN FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES STUDENTS/INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION

FINDINGS:

DF does not use students, interns or detainees in the delivery of health care.

Standard #1-HC-2A-18 REVISED AUGUST 2008

UNLESS PROHIBITED BY STATE LAW, OFFENDERS (UNDER STAFF SUPERVISION) MAY PERFORM FAMILIAL DUTIES COMMENSURATE WITH THEIR LEVEL OF TRAINING. THESE DUTIES MAY INCLUDE:

- PROVIDING PEER SUPPORT AND EDUCATION
- ENGAGING IN HOSPICE ACTIVITIES
- ASSISTING IMPAIRED OFFENDERS ON A ONE-ON-ONE BASIS WITH ACTIVITIES OF DAILY LIVING

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- SERVING AS SUICIDE COMPANION OR BUDDY IF QUALIFIED AND TRAINED THROUGH A FORMAL PROGRAM THAT IS PART OF SUICIDE PREVENTION PLAN
- HANDLING DENTAL INSTRUMENTS FOR THE PURPOSE OF SANITIZING AND CLEANING, WHEN DIRECTLY SUPERVISED AND THEN IN COMPLIANCE WITH APPLICABLE TOOL CONTROL POLICIES, WHILE IN A DENTAL ASSISTANCE TRAINING PROGRAM CERTIFIED BY THE STATE DEPARTMENT OF EDUCATION OR OTHER COMPARABLE APPROPRIATE AUTHORITY

OFFENDERS ARE NOT TO BE USED FOR THE FOLLOWING DUTIES:

- PERFORMING DIRECT PATIENT CARE SERVICES
- SCHEDULING HEALTH CARE APPOINTMENTS
- DETERMINING ACCESS OF OTHER OFFENDERS TO HEALTH CARE SERVICES
- HANDLING OR HAVING ACCESS TO SURGICAL INSTRUMENTS, SYRINGES, NEEDLES, MEDICATIONS, OR HEALTH RECORDS
- OPERATING DIAGNOSTIC OR THERAPEUTIC EQUIPMENT EXCEPT UNDER DIRECT SUPERVISION (BY SPECIALLY TRAINED STAFF) IN A VOCATIONAL TRAINING PROGRAM

FINDINGS:

LDF does not use detainees to perform familial duties.

Standard #1-HC-3A-06-1 ADDED JANUARY 2002

WRITTEN POLICY, PROCEDURE AND PRACTICE PROVIDE FOR THE ASSIGNMENT OF APPROPRIATELY TRAINED, INDIVIDUALS TO ASSIST DISABLE OFFENDERS WHO CANNOT OTHERWISE PERFORM BASIC LIFE FUNCTIONS.

FINDINGS:

LDF does not house detainees who cannot perform basic life functions.

Standard #1-HC-7C-01

THE PROGRAM PROVIDES FOR RECRUITING CITIZENS FOR INVOLMENT AND FOR VOLUNTEERS. THE SCREENING AND SELECTION OF VOLUNTEERS ALLOW FOR RECRUITMENT FROM ALL CULTURAL AND SOCIALECONOMIC PARTS OF THE COMMUNITY.

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FINDINGS:

LDF does not utilized volunteers in the delivery of health care services.

Standard #1-HC-7C-02

EACH VOLUNTEER COMPLETES AN APPROPRIATE, DOCUMENTED ORIENTATION AND/OR TRAINING PROGRAM PRIOR TO ASSIGNMENT.

FINDINGS:

LDF does not utilized volunteers in the delivery of health care services.

Standard #1-HC-7C-03

THERE IS AN OFFICIAL REGISTRATION AND IDENTIFICATION SYSTEM FOR VOLUNTEERS.

FINDINGS:

LDF does not utilized volunteers in the delivery of health care services.

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Significant Incident Summary
This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: LaSalle Ice Processing Center Reporting Period: OCT, 2016 –SEPT, 2017

Incident Type	Months →	OCT 2016	NOV 2016	DEC 2017	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUNE 2017	JULY 2017	AUG 2017	SEPT 2017	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	1	0	0	0	0	1	0	0	1	1	4	8
	Offender/ Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0	0

- *May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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LaSalle Detention Facility (IHSC)
Dates: Oct, 2016-Sept, 2017

		Health Care Outcomes		
Standard	**Outcome Measure**	**Numerator/Denominator**	**Value**	**Calculated O.M.**
1A	(1)	Number of offenders diagnosed with a MRSA infection within the past twelve (12) months	2	
	divided by	The average daily population	1136	0.00176
	(2)	Number of offenders diagnosed with active tuberculosis in the past twelve (12) months	3	
	divided by	Average daily population.	1136	0.00264
	(3)	Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months	7	
	divided by	Number of offenders administered tests for TB infection in the past twelve (12) months as part of periodic or clinically-based testing, but not intake screening.	39	0.17948
	(4)	Number of offenders who completed treatment for latent tuberculosis infection in the past twelve (12) months	7	
	divided by	Number of offenders treated for latent tuberculosis infection in the past twelve (12) months.	7	1
	(5)	Number of offenders diagnosed with Hepatitis C viral infection at a given point in time	5	
	divided by	Total offender population at that time.	1136	0.0044
	(6)	Number of offenders diagnosed with HIV infection at a given point in time	2	
	divided by	Total offender population at that time.	1136	0.0017

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	(7)	Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time	2	
	divided by	Total number of offenders diagnosed with HIV infection at that time.	2	1
	(8)	Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less than 50 cps/ml	1	
	divided by	Total number of treated offenders with HIV infection that were reviewed.	2	0.5
	(9)	Number of offenders with an active individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time	19	
	divided by	Total offender population at that time.	1136	0.01672
	(10)	Number of offender admissions to off-site hospitals in the past twelve (12) months	22	
	divided by	Average daily population.	1136	0.01936
	(11)	Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months	363	
	divided by	Average daily population in the past twelve (12) months.	1136	0.31954
	(12)	Number of offender specialty consults completed during the past twelve (12) months	1988	
	divided by	Number of specialty consults (on-site or off-site) ordered by primary health care practitioners in the past twelve (12) months.	1947	1.02105
	(13)	Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mmHg/ >90 mm Hg	26	
	divided by	Total number of offenders with hypertension who were reviewed.	26	1
	(14)	Number of selected diabetic offenders at a given point in time who are under treatment for at least six months with a	1	

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		hemoglobin A1C level measuring greater than 9 percent		
	divided by	Total number of diabetic offenders who were reviewed.	11	0.09090
	(15)	The number of completed dental treatment plans within the past twelve (12) months	51	
	divided by	the average daily population during the reporting period.	1136	0.04489
2A	(1)	Number of health care ***staff*** with lapsed licensure or certification during a twelve (12) month period	0	
	divided by	Number of licensed or certified staff during a twelve (12) month period.	(b)(7)(E)	
	(2)	Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job		
	divided by	Number of new health care staff during the twelve (12) month period.		
	(3)	Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months	0	
	divided by	Number of employees.	(b)(7)(E)	0
	(4)	Number of direct care staff (employees and contractors) with a conversion of a TB test that indicates newly acquired TB infection in the past twelve (12) months	0	
	divided by	Number of direct care staff tested for TB infection in the past twelve (12) months during periodic or clinically indicated evaluations.	(b)(7)(E)	0
3A	(1)	Number of offender grievances related to health care services found in favor of the offender in the past twelve (12) months	3	
	divided by	Number of evaluated offender grievances related to health care services in the past twelve (12) months.	103	0.0291
	(2)	Number of offender grievances related to safety or sanitation sustained during a twelve (12) month period	2	
	divided by	Number of evaluated offender grievances related to safety or sanitation during a twelve (12) month period.	2	1

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	(3)	Number of adjudicated offender lawsuits related to the delivery of health care found in favor of the offender in the past twelve (12) months	0	
	divided by	Number of offender adjudicated lawsuits related to healthcare delivery in the past twelve (12) months	0	0
4A	(1)	Number of problems identified by quality assurance program that were corrected during a twelve (12) month period	2	
	divided by	Number of problems identified by quality assurance program during a twelve (12) month period.	2	1
	(2)	Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period.	0	
	(3)	Number of offender suicide attempts in the past twelve (12) months	1	
	divided by	Average daily population	1136	8.8028
	(4)	Number of offender suicides in the past twelve (12) months	0	
	divided by	Average daily population	1136	0
	(5)	Number of unexpected natural deaths in the past twelve (12) months	0	
	divided by	Total number of deaths in the same reporting period.	0	0
	(6)	Number of serious medication errors in the past twelve (12) months	0	
5A	**None**			
6A	**None**			
7A	**None**			
7B	**None**			
7C	**None**			

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

CoreCivic
Otay Mesa Detention Center
San Diego, California

November 11 - 13, 2019

VISITING COMMITTEE MEMBERS

(b)(6); (b)(7)(C) Chairperson
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

(b)(6); (b)(7)(C)
ACA Auditor

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A. Introduction

The reaccreditation audit of the CoreCivic Otay Mesa Detention Center in San Diego, California was conducted on November 11-13, 2019, by the following team: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Chairperson (b)(6); (b)(7)(C) Member; and (b)(6); (b)(7)(C) Healthcare Member.

B. Facility Demographics

Rated Capacity:	2084
Actual Population (11/11/19):	1769 (1186 ICE/583 USMS)
Average Daily Population for the last 12 months:	1420
Average Length of Stay:	83 days
Security/Custody Levels contracted:	Minimum and Medium
Age Range of Detainees:	18 - 70
Gender:	Male and Female

(b)(7)(E)

C. Facility Description

The Otay Mesa Detention Center (OMDC) is privately owned and operated by CoreCivic. The facility's physical address is 7488 Calzada De La Fuente, San Diego, California. Although the facility is near a major metropolitan area, it is ideally located in an isolated area surrounded by a State Prison, County Sheriffs Detention Facility, and a County Juvenile Center, all within a three mile radius of one another. The facility is also located within three miles of the International Border San Diego-Tijuana; therefore, much of the area surrounding the facility is monitored and patrolled by US Custom and Border Patrol agents.

OMDC is considered a minimum/medium security level facility and houses adult male and female detainees through a partnership with the Immigration and Customs Enforcement Agency (ICE) and the United States Marshal Service (USMS).

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Three types of detainees are being are housed: 1) ICE detainees who are awaiting court, asylum in the United States, or asylum to other countries; 2) Justice Prisoner and Alien Transport System (JPATS) ICE detainees awaiting aerial transport to their home country or asylum country after deportation has been ordered; and 3) United States Marshals Service detainees awaiting sentencing or further court proceedings. The 2019 Staffing Pattern identifies 1422 ICE beds and 548 USMS beds, which fluctuate. The Intake Department processes, on average, 60 new admissions each day and 20 releases a day; the numbers are increasing due to the addition of the four new housing units. The average length of stay for ICE and USMS detainees is 83 days.

Programs and services at OMDC include High School Equivalency Test, English as a Second Language, life skills classes, religious services, volunteer services, counseling services, and recreational activities.

The Otay Mesa Detention Center mission is "to operate a safe, secure, clean, constitutional, consistent and professional facility by exhibiting our commitment to excellence, empowering the staff to conduct their duties with P-R-I-D-E, and providing care and programs for those committed in our care."

Otay Mesa Detention Center employs up to (b)(7)(E) At the time of the visit, there were (b)(7)(E) Healthcare is contracted to Department of Homeland Security, ICE Health Service Corp (IHSC) who provides (b)(7)(E) site staff. Food Service is contracted to the Trinity Service Group who provides (b)(7)(E) staff. ICE Detachment operates out of OMDC with approximately (b)(7)(E) personnel from Deportation, Removal, Asylum, and District Counsel; and the Executive Office for Immigration Review (EOIR) Immigration Court is a component of the Department of Justice (b)(7)(E) permanently assigned Judges hold court on-site at OMDC while (b)(7)(E) udges are assigned on a rotational basis for video court hearings. Prior to employment, all staff receives a background check, drug screening, TB test, and medical screening. Staff is required to attend initial and annual training at Otay Mesa Detention Center. Staff training is offered on-line through e-learning, in addition to traditional classroom training.

Original construction of the facility was complete in 2015 with an operational capacity of 1572. During the audit cycle, four units/512 beds were added with a completion date of October 14, 2019, which increased the total capacity to 2084 beds. The facility occupies approximately 37 acres of which approximately 16 acres are within the perimeter fence. A two-story conventional steel structure houses the entire facility under one roof and is cladded with insulated precast concrete wall panels. There are no buildings outside the perimeter fence.

Individuals enter through the interlocked front gates (pedestrian sally port), and then proceed to the lobby area of the administration building. The public video visitation area is on the left side of the lobby; to the right is the waiting area for both visitors and legal representatives.

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On the far right of the arrival lobby is a stairway to the second floor which contains: attorney visitation rooms (seven), a contact visitation room (one), asylum interview rooms (four), telephonic rooms, and the Executive Office of Immigration Review court rooms (five). The remainder of the second floor is the administration area for (b)(7)(E) mmigration and Customs Enforcement staff, and (b)(7)(E) staff of the Executive Office of Immigration Review (including (b)(7)(E) judges).

The first-floor arrival lobby has an additional secure door to the administration area, which includes offices for the warden, warden's secretary, business department, human resources, assistant wardens, investigator, and the quality assurance manager. Also, in this area is the staff computer lab, electrical room, copier/print room, staff break room and restrooms, mailroom, staff gym, conference room/facility command post, meeting room, and staff locker rooms for females and males.

Central control is located between the administration area and the main corridor and serves as the two-door slider sally port entry area into the main corridor, which runs across the detention center to all housing units and all activities areas and is approximately one quarter of a mile long.

Each housing area has handicap accessible cells/dorms, and showers and restrooms for the diverse population. Inmate housing areas are constructed of exterior and interior precast concreate walls and precast concrete modules. All units are designed for direct supervision. ICE and US Marshal detainees do not mingle, and they are not housed together.

The six dormitory style housing units provide 658 beds and are comprised of a large open dayroom area with centralized group toilet, sink, and shower areas. The 15 cell housing units provide 1420 beds (not including 6 isolation cells) and are comprised of two or four person cells with a toilet/sink combo unit and large open dayroom areas with showers and sinks. Each unit has its own partially covered recreation area located at the back of units.

The medical infirmary is comprised of two dormitory units with nine mental health beds in each dorm, 14 single cells for various mental conditions, and six negative pressure isolation rooms.

The left side of the lengthy main corridor contains Pods A-H, J-M, and Q-R. Recreation yards are attached to all housing units. Video visitation rooms are located between units to facilitate visits. Satellite law libraries are located in units for remote access to legal material.

The two restrictive/segregation housing units house male and female detainees in an administrative, disciplinary, protective, or self-admitted status. C2-Pod is dedicated as the female segregation unit, is located inside of and off to the right of C2 and includes six cells with two beds in each. D-Pod is dedicated as the male segregation unit and includes 32 cells with two beds in each. Two-man cells provide 98 total square feet and 37 square feet unencumbered space per person. Cells contain a call button tied to central control. An officer's podium is located at the entrance of each unit.

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Due to the location and design of C2 Segregation, access to natural lighting is non-existent in the first four cells as described under the environmental section below. An OMDC Segregation Plan was in place for services and programs available to detainees housed in segregation i.e., commissary, property, television, telephone, etc. An officer started a creative writing/poetry program for detainees, which is very popular. Documentation and interviews verified staff visits, the delivery of programs and services, and 30-minute rounds by staff. During the visit, seven females were housed in C2-Pod and 14 US Marshals and 14 ICE males were housed in D-Pod.

Interspersed along the corridor between the various pods are unit management offices and storage rooms/janitorial/chemical closets.

The right side of the main corridor contains:

- Control Center (for secure housing and video coverage of recreation yard)
- Security Offices
- N and P Pod Dormitories
- T and V Pods
- Corridor to Intake, Property, Discharge, Medical Clinic and Medical Housing
- Corridor to Commissary/Warehouse, Maintenance, Kitchen
- Corridor to Classrooms, Detainee Gymnasium, second Staff Gymnasium, and Barbershop
- All Medical Housing
- Medical/Dental/Mental Health Clinics
- Medical Clinic/Medical space (vacant)
- Elevator to upstairs Court Rooms, Attorney Visitation, and Contact Visitation
- Holding Cells
- Offices for Training Manager, Disciplinary Hearing Office, and Shift Supervisor
- Laundry
- Electrical spaces
- Dining Hall (East)
- Dining Hall (West)
- Chapel
- Law/Leisure Library

Core Civic Otay Mesa Detention Center Bed Capacity			
Housing Unit	Total Beds	Type	Detainees Housed
A-Pod	128	16 dorms/8 beds ea. 25.625 sq. ft. ea.	ICE female housing dorm
B-Pod	100	50 dbl bunk cells 37 sq. ft. ea.	USMS female housing/ satellite clinic

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C1 Pod	14	7 dbl bunk cells 37 sq. ft. ea.	ICE female housing/satellite law library
C2 Pod	12	6 dbl bunk cells 37 sq. ft. ea.	Female segregation/satellite law library
D-Pod	64	32 dbl bunk cells 37 sq. ft. ea.	Male segregation/satellite clinic/satellite law library
E-Pod	64	32 dbl bunk cells 37 sq. ft. ea.	USMS female housing/ satellite clinic/satellite law library
F-Pod	128	16 dorms/8 beds ea. 25.625 sq. ft. ea.	USMS male dormitory housing
G-Pod	128	64 dbl bunk cells 37 sq. ft. ea.	USMS male housing/ satellite law library/satellite clinic
H-Pod	128	64 dbl bunk cells 37 sq. ft. ea.	USMS male housing/ satellite law library/satellite clinic
J-Pod	128	64 dbl bunk cells 37 sq. ft. ea.	ICE male housing/satellite law library
K-Pod	128	16 dorms/8 beds ea. 25.625 sq. ft. ea.	ICE male housing/satellite law library
L-Pod	128	64 dbl bunk cells 37 sq. ft. ea.	ICE male housing/ satellite law library
M-Pod	128	64 dbl bunk cells 37 sq. ft. ea.	ICE male housing/ satellite law library
N-Pod	128	16 dorms/8 beds ea. 25.625 sq. ft. ea.	ICE male housing/satellite law library
P-Pod	128	16 dorms/8 beds ea. 25.625 sq. ft. ea.	ICE male housing/satellite law library
Q-Pod	128	64 dbl bunk cells 29 sq. ft. ea.	ICE male housing/satellite law library
R-Pod	128	64 dbl bunk cells 29 sq. ft. ea.	ICE male housing/satellite law library
T-Pod	128	32 quad bunk cells 29 sq. ft. ea.	ICE male housing/satellite law library
V-Pod	128	32 quad bunk cells 29 sq. ft. ea.	ICE male housing/satellite law library
Medical Infirmary	18	2 dorms/9 beds ea. 50.9 sq. ft. ea.	Mental Health
Medical Infirmary	14	14 single cells 74 sq. ft.	All Conditions
Respiratory Isolation	6	6 single cells	
Total Beds	2084		

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D. Pre-Audit Meeting

The visiting committee met for dinner on November 10, 2019, in Chula Vista, California with executive staff to discuss the information provided by the Association staff and the officials from the CoreCivic Otay Mesa Detention Center.

The chairperson divided standards into the following groups:

Standards 1B-01 to 3A-02 and 6B-01 to 6D-01 (b)(6); (b)(7)(C)
Standards 4A-01 to 5A-10 (b)(6); (b)(7)(C) Healthcare Member
Standards 1A-01 to 1A-23, 5B-01 to 6A-09, 7A-01 to 7G-01 (b)(6); (b)(7)(C) Chairperson

E. The Audit Process

1. Transportation

The visiting committee was escorted to and from the facility each day by Quality Assurance Manager (b)(6); (b)(7)(C)

2. Entrance Interview

The visiting committee arrived at Otay Mesa Detention Center at 7:40 a.m., checked in, and cleared through front entry. The team proceeded to the warden's conference room where the formal entry meeting was held. Due to the Federal Holiday, many staff was scheduled off.

The following persons were in attendance:

(b)(6); (b)(7)(C)

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The team expressed the appreciation of the Association for the opportunity to be involved with the Otay Mesa Detention Center in the accreditation process. Warden LaRose stated there were no requests from the public, staff, or detainees to visit with the audit team as a result of the audit posting; there were no lawsuits during the audit cycle that had an adverse judgment against the facility or its employees; and there were no current issues that would jeopardize the accreditation status.

Warden LaRose welcomed the visiting committee and the attending staff members introduced themselves. The team members introduced themselves and provided information about their background. It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit, team members would visit as many departments and areas as possible and meet and speak with as many staff and detainees as possible in the time available, and the team would meet with the warden at the end of each day for an out brief. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The visiting committee toured the entire facility from 8:50 a.m. to 4:30 p.m. with a break for lunch. The posting of audit announcements were displayed for detainees, staff, and visitors. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

(b)(6); (b)(7)(C)

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

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Security:

(b)(7)(E)

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(b)(7)(E)

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(b)(7)(E)

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(b)(7)(E)

Assistant Warden (b)(6); (b)(7)(C) was the assigned Prison Rape Elimination Act (PREA) Coordinator at OMDC. PREA signs were posted throughout the facility. All females must announce their presence upon entering male housing areas and vice versa for males entering female units, which was observed by the visiting committee. PREA information is provided in the detainee handbook and orientation video, which were available in English and Spanish. It was reported that the facility underwent a successful DOJ PREA audit June 23, 2018.

Classification

Since the average stay here is only about 83 days and since most detainee's face deportation, the main objective in classification is to house every detainee in a proper and secure environment based on their background, group affiliations, and to a lesser degree, their personal needs and assessments. Classification is geared towards identifying and separating criminal gang members who are hostile to each other as well as identifying potential terrorist members and those with violent tendencies for referral to investigative agencies.

Classification of the detainee population is conducted during the intake process and the detainee's security level (one, two, or three) is determined by criminal background, age group, and education level. During the initial interview, other information is gathered from the detainee, i.e. biographical information, criminal history, gang or STG affiliation, predatory history, and social habits (smoking, alcohol, drugs, etc.). All information is then verified and/or cross-referenced with official ICE or US Marshals records for validity, and a security level is assigned. The detainee is moved to the appropriate general population housing assignment according to their classification level and affiliations.

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Environmental Conditions:

Otay Mesa Detention Center was constructed in 2015 and is considered "new construction" under the Adult Local Detention Facilities standards. Four new housing units were added during the audit cycle with a completion date of October 14, 2019. All housing areas provide the required unencumbered living space, which ranges between 25.625 to 50.9 square feet per detainee. Handicap assessable housing is available for detainees with disabilities. (b)(6); (b)(7)(C) Facility Manager at California Correctional Facility conducted an Environmental Data Report on February 28, 2019, and reported airflow, daytime and nighttime noise levels, and lighting levels all met standard requirements. The temperature in all areas felt comfortable during the visit. Documented toilet/urinal, washbasin, and shower ratios all met standard requirements. Random fixtures were tested by the visiting committee and the hot water at showers and washbasins felt very warm to the touch. Several colorful murals were painted on walls. Furnishings throughout the facility were in good condition. Each detainee is provided one storage tote box and a clear plastic bag for the storage of personal items, and a pillowcase for laundry. Detainees are issued limited hygiene items once a week with a one for one exchange; additional items can be purchased through the commissary. A barbershop is located in each housing unit and the gym. Detainees can sign up for haircuts.

Dayrooms are immediately adjacent to cell/dormitory living areas for indoor leisure time activities and required square footage was met. Each dayroom provides telephones, a C-ORES kiosk, satellite law library, televisions, tables and seats, microwaves, igloos with water, ice in coolers, and some pods have security grade couches and a multi-purpose room. A ping pong table is located in all ICE detainee pods. D-Pod (male segregation) provides two indoor expanded metal cages/dayrooms for eligible detainees. Each pod also has a partially covered outdoor recreation area off the back of the unit. Dayrooms typically provide (14) 4'x4' skylights and two 8'0"x10'6" security windows at the end of the dayroom for natural light. Cell doors contain two 4.75"x29.5" windows for a total of 1.94 square feet transparent glazing, which is important because cells have one 41"x5" partially distorted window at the back of the cell so detainees cannot see into the mechanical room/pipe chases (windows face the two-story narrow pipe chase space, with very little light from a few skylights high above). A daylight harvesting system can control the interior lights as needed throughout the day, but this is done manually at present.

One housing area of concern, pertaining to natural light, was C2-Pod (female segregation) which is a housing unit within a housing unit. Although this is a newer facility, this housing area appears to be a design flaw. This housing area contains 6 cells that face a concrete wall. As described above, the back window is distorted because if faces the pipe chase so there is no natural light. There is one window on the door at the end of the hall in this unit, which may provide a little outside light to the first and maybe the second cell.

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All detainees are offered two hours of out-of-cell time for dayroom and recreation, but they are confined the remainder of the day. Detainees can self-admit themselves into segregation for an unknown amount of time and in fact, during the visit a female in Pod C2, cell 123 (b)(6); (b)(7)(C) had been in segregation since 6/14/2017 (over two years) with the exception of about four days, and she refuses to go to recreation. It was recommended that this female detainee be moved to the last cell next to the outside door/window for some natural lighting.

The maintenance department is staffed with seven general maintenance positions; due to the expansion one additional position is being added. A preventative maintenance plan was in place, which identified equipment that is checked weekly, monthly, quarterly, semi-annually, and annually; this includes ventilation, plumbing, lighting, and fire and safety systems. Staff maintains four emergency generators; no-load tests are conducted weekly and a full-load test semi-annually. The maintenance shop was very clean and organized; tools were engraved, secured on shadow boards or on carts, and were properly accounted for. Caustics were stored in flammable cabinets with the presence of safety data sheets, personal protective equipment, eyewash stations, and an oily waste can.

This is an LEED (Leadership in Energy and Environmental Design) certified Silver facility since July 31, 2015. A solar water system preheats the water for central mechanical room and provides hot water to the entire facility. The facility is piped for recycled water and hopes to connect to the Otay Water District in the future. The HVAC needs are provided by roof top mounted HVAC units aligned along the roof ridge of the building. In addition, Aqua Recycle, a laundry recycle system is in place. The system is designed to eliminate sewer and water connections by recycling washing machine discharge water.

Sanitation:

A daily housekeeping plan was in place (OMDC Policy 12-100) effective September 1, 2015. The safety manager is responsible for coordinating and monitoring chemicals and sanitation. Overall, sanitation throughout the facility was found to be at an exceptional level. Walls, ceilings, vents, floors, showers, toilets, and living areas were all clean; there was no evidence of old dirt; there were no foul odors present; offices were free of clutter; and grounds were free of trash. Ongoing cleaning was observed throughout the facility in all areas. Concentrate chemicals are initially received in Supply Room #1950 on the north back dock. Five gallon Spartan cleaning agents jugs are delivered to and diluted by dilution stations located in three janitor closets in the main corridor; thus products handled by detainees are non-hazard with a 0 or one rating; spray bottles were properly labeled; safety data sheets, personal protective equipment, and eyewash stations were present where concentrate chemicals are stored. Weekly inspections are conducted by trained/qualified staff and monthly inspections are conducted by the safety manager. Otay Water District in Spring Valley, California provides potable water.

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Solid waste goes to Otay City Sewage, but the facility is responsible for maintaining a grinder for large items which is cleaned out daily by maintenance staff. Eco Lab Pest Control is contracted to provide monthly pest control services.

Fire Safety:

Otay Mesa Detention Center employs one full-time safety manager to oversee the fire safety program. The facility's fire protection and detection systems include a visual and audible fire alarm system with duct smoke detectors, heat detectors, smoke detectors, and pull stations throughout, and the main annunciator is located outside of central control with sub panels throughout. An Ansul hood suppression system is located in the kitchen. A wet pipe sprinkler system is located in all areas. Systems are inspected, tested, and serviced in accordance with manufacture's recommendations by Siemens Fire Life Safety. All systems were operational during the visit. Third quarter fire drills were conducted on all shifts and in all areas of the facility for the fourth quarter 2019. Drills are simulated in special housing areas. Evacuation diagrams were properly posted throughout the facility in English and Spanish. Emergency lighting was present and exit signs were illuminated. Officers have the availability to open all electronic doors at once with a gang release located in central control and emergency keys are readily available for immediate release of detainees, if needed. Approximately 227 fire extinguishers were available throughout the facility and in all transport vehicles; tags indicated monthly inspections are conducted. Twenty-two fire hydrants are strategically located along the outer perimeter.

The Cal-Fire Marshal in San Diego is the authority having jurisdiction. On April 22, 2019, (b)(6); (b)(7)(C) Fire Prevention Specialist II, San Diego County Fire Authority conducted an annual inspection and reviewed emergency evacuation plans; there were no code violations. Weekly safety and sanitation inspections are conducted by trained/qualified staff and monthly inspections are conducted by the facility safety manager. If assistance from a fire department is required, the facility has a Memorandum of Understanding for mutual aid and support with San Diego County Rural Fire Department which is located approximately two miles from the facility, with a response time of approximately four minutes. All facility staff is trained in the implementation of facility emergency procedures. OMDC is a tobacco free facility.

The visiting committee found caustics, flammables, and toxic items to be properly stored in flammable cabinets and inventoried throughout the facility. The H42 clipper cleaner in barbershops required stricter control and accountability, which was corrected immediately. Safety Data Sheets, personal protective equipment, eyewash stations, and an oily waste can were present where chemicals are stored and distributed. All areas account for open/partially used caustic/toxic chemicals as one rather than using an accurate inventory system.

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The visiting committee recommends that at a minimum, dangerous materials with the words "warning, danger, keep out of reach of children" or with hazard ratings of moderate, serious, or severe be weighted for an accurate accountability.

Food Service:

The Otay Mesa Detention Center Food Service Department is operated through a contract with Trinity Services Group, Inc. to provide detainee and staff meals. Staffing includes (b)(7)(E)
(b)(7)(E)
Approximately 105 volunteer ICE detainees are assigned to work one of three shifts. One correctional officer is assigned to the kitchen to maintain security and ensure timely flow of the meal time. The large kitchen includes a food preparation area, sandwich area, bakery area, dry storage area, one walk-in refrigerator, one walk-in freezer, a dishwashing area, pots and pans area, and two blind feeding serving lines. Two detainee dining halls offer a seating capacity of 217 each. Insulated food trays are transported to the segregation units, medical, and intake. Detainees are required to swipe their ID badge at a computer prior to receiving a meal tray in the dining hall. Breakfast is served at 5:15 a.m., lunch 11:00 a.m., and dinner 4:00 p.m. The staggered feeding schedule allows detainees 20 minutes to consume their meal. A five-week cycle menu is followed, and menus are approved by a registered dietician employed by Trinity. The 2019 diet for health menu provides detainees an average of 2800 calories a day. The average meal cost is $1.386. At least two hot meals are served each day. Special diets are provided for medical and religious purposes and diet manuals were present in the kitchen and medical department. During the visit, 188 medical diets were prescribed, and 117 religious diets were approved. All staff receives free meals, which can be consumed in one of the four staff breakrooms.

The kitchen was clean, organized, and efficient during the review. Food preparation tools were engraved, neatly shadowed, inventoried, and controlled. All equipment was in good working condition. Knifes are not allowed in the kitchen; dough cutters are used instead. Paddles and dough cutters were secured by the use of a tether system, and the can opener was locked. Daily detainee and staff health checks are being conducted and documented. Safety training is provided monthly. Freezer, cooler, ambient air, and dishwashing temperatures were being maintained appropriately. Seventy-two hour meal samples were available. Hairnets, beard nets, hand washing sinks with hot water, soap, towels, trash can, and notifications signs were all in evidence. All storage was off the floor; both staff and detainee workers appeared trained in public health requirements. There was no evidence of rodents or insects. Christine Tham, Specialist with the County of San Diego Department of Environmental Health conducted an annual Sanitation and Health Inspection on April 16, 2019, with one deficiency that was corrected; OMDC received a score of 98%.

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The lunch meal was sampled in the kitchen on Monday. The meal consisted of two turkey frankfurter hotdogs, two hotdog buns, ½ cup steamed cabbage, one cup baked beans, one cookie, two mustard packs, and one cup beverage. The flavor, texture, temperature, appearance, and palatability were all good and the portions were of sufficient quantity.

Detainees have access to a commissary which is run by six staff and nine detainees. Keefe provides the commissary products. Commissary bags are delivered to the units. Detainees can spend up to $80.00 a week. Radio, MP3 Player/music, stamps, shoes, and clothing are not part of the spending limit. Detainees may fill out commissary orders through the C-ORES Kiosks located in the dayroom. C-Mail is available for USMS detainees. The dry storage/ambient air temperature was not being recorded in the commissary to ensure food items such as tortillas are not compromised.

Medical Care:

Healthcare services are provided by the Department of Homeland Security, ICE Health Service Corp. The facility does operate an Infirmary. Below is a list of medical staff at Otay Mesa Detention Facility:

(b)(6); (b)(7)(C); (b)(7)(E)

The Dental Department does have an autoclave in use. Spore testing of the autoclave is done on a weekly basis in accordance with the approved testing procedure.

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A record of the indicators and results are maintained in the Dental Department. Responsibility for testing will be the dental assistant or dental hygienist. Responsibility for maintaining spore testing results will be the dental staff.

A random inventory of accountability practices for medications and dental/medical instruments and all flammables was conducted during the on-site visit. The facility was found to have excellent accountability practices for the control of narcotics and general medications.

The medical providers are on-call 24-hours, seven days a week. Dental providers are on-call during the same time frame. Mental health providers also are on-call during the previously mentioned schedule.

STG International provides healthcare contract staff for Otay Mesa Detention Facility. Laboratory specimens are collected seven days per week and are then transferred to LabCorp. LPNs and RNs are responsible for the collection of lab specimens. The results of the lab specimens are sent to the facility electronically.

The facility does have radiology on-site. However, it is used for TB screening only. This is available seven days per week. For emergency/urgent radiology exams, the detainees are sent off-site. When radiology examinations are completed, the results are received via radiology report immediately or at least within 12 hours. The majority of results are received immediately.

Pharmacy services are provided by PHS. The facility has currently (b)(7)(E) (b)(7)(E) (b)(7)(E) The pharmacy itself is very well stocked. Medications are delivered to the facility by courier. Medications are received two to three times per week. The courier calls the pharmacy once arrived at the facility. A pharmacy staff member meets the courier in the front lobby to retrieve medication totes. Once inside the pharmacy, the staff member checks medications received against invoice before stocking. The pharmacy has designated bins in the pill line room. Pharmacy staff picks up bins on a weekly basis. The pharmacy does not utilize an automatic renewal system.

Pill lines are distributed each day of the week at 5:00, 11:00, 4:00, and 8:00. Keep-on-person medications are delivered to the detainees between 7:00 and 10:00. A detention officer is present during medication distribution times. Detainees are able to purchase over-the-counter medications from the commissary.

Detainee sick call (routine) is available seven days per week. Detainees sign up for sick call between 5:00 and 6:00 hours daily. Detainees' requests for health services are triaged seven days per week.

Restrictive housing is visited several times throughout the day for the distribution of medications, etc.

AMERICAN OVERSIGHT

The medication is distributed to detainees in restricted housing by the nurse going from room to room. An LVN or RN personally delivers the medications to the restricted housing area.

Typically, Alvarado ER is utilized for 911 emergencies. The detainee is transported by Emergency Medical Services (EMS). The hospitals detainees are transported to are Alvarado, Sharp CV, Sharp Grossmont, UCSD La Jolla, UCSD Hillcrest, Scripps CV, Scripps Hillcrest, Paradise Valley, or Select Specialty/Vibra.

The facility has a total of nine automatic external defibrillators (AEDs).

The facility does have an infirmary on-site. The infirmary has a total of 38 beds for patient care. Six of these rooms are rooms are utilized for respiratory isolation. The configuration of the infirmary beds are 18 dorm beds, four single room beds, and 6 negative pressure rooms.

The facility does have rooms used for suicidal observation. These rooms are in the medical housing unit. The facility has all the appropriate observation clothing at its disposal. The facility has the ability to watch detainees constantly while housed in these rooms. In fact, day one of the visit, there was a detainee under one-on-one direct observation.

The facility offers annual physical examinations for the detainees in the case of a long-term detainee. The annual physical examination date is determined by the detainee's date of incarceration.

The facility does a follow-up on detainees with chronic health care problems at least every 90-days; generally, much more often. The individual treatment plan for chronic care patients is developed by an advanced practice provider (nurse practitioner or physician assistant).

Optometry services are provided by an off-site provider.

Waste management is collected from the medical area and stored in an outside locked bin until it is collected. When a bin is two-thirds full, it is removed from the nursing unit and placed in the locked bins outside. Medical waste is collected and transported off facility grounds on a monthly basis. The contractor for the medical waste is provided by HealthWise Services.

The facility does utilize telemedicine. Telemedicine presentations are conducted Tuesday through Thursday. Specific telemedicine specialty clinics are for such things such as: infectious disease, diabetes, hypertension, and psychiatry. The off-site telemedicine conferences take place at the university, hospital, physician office, central office, etc., as well as Krome Detention Facility in Miami, Florida. The credentials of facility staff that present telemedicine patients are RNs, LVNs, as well as psychiatric staff.

AMERICAN OVERSIGHT

The facility utilizes electronic medical records (EMR). The facility also continues to retain a paper medical record. The EMR contains all medical, dental, and mental health information.

The facility conducts dialysis for detainees. The dialysis is done off-site by a medical contractor, Select Specialty Hospital.

This visiting committee observed staff that had a compassionate and caring approach to the detainee's well-being, both medical and mental health. Upon observation, all departments work well together, and respect was observed from all employees to one another. The medical area was clean, organized, and all medical staff presented a professional and caring approach. It was observed that security and the medical department work very well together for the safety of the staff and detainees.

Mental health services are available to all individuals in custody. Upon arrival to the facility, individuals go through the intake process at which time they are asked mental health related questions. If they answer yes to any questions, they are immediately referred to mental health. Another point of referral is from medical providers who assess during their physical examinations or other ongoing medical issues. Once the mental health referral is received, the individual is seen within 72 hours. When they are seen for the first time, a full comprehensive mental health evaluation is completed. Follow-up appointments are available as clinically warranted or as requested. Individuals are educated on their options for services at which time they can accept or decline. Services are strictly voluntary. If they decline, they are educated on the use of sick call process, which is offered daily, during which time they can sign up to request a meeting with mental health. Individuals can choose to start and stop services at will.

While in care, individuals are offered individual counseling by LCSW or Psychologists. Also, they have access to Psychiatry, Psychiatric NP, and Psych Pharmacist for medication management. Treatment is individualized in nature and they are scheduled follow up appointments, as clinically indicated.

Mental health staff members are on-site seven days out of the week during which time they are available to not only see scheduled individuals but any emergent matters that may arise.

The OMDC medical department was accredited by the National Commission on Correctional Health Care (NCCHC) September 2017.

Recreation:

Otay Mesa Detention Center employs one recreation supervisor, one recreation coordinator, and two gymnasium officers to coordinate daily recreation activities.

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All detainees are afforded at least one hour of recreation each day either inside or outside, and San Diego weather permits year-round access to outdoor activity. The indoor recreation schedule indicates, by housing units, the specific times detainees have access to the 7,374.57 square foot gymnasium at least one hour two days a week. The gymnasium offers basketball, volleyball, corn hole, bat mitten, and workout classes; restroom facilities are also available in the gym. Each housing unit has an outdoor recreation area off the back of the unit, which allows the detainees to go to the yards throughout the day. These yards are equipped with a basketball hoop, pullup bar, and picnic table. The outdoor yards provide 1923 square feet of space; C1 yard provides 1525.18 square feet. Special housing units have their own outdoor, cage style modules, that are reasonable in size and provide access to fresh air as follows: Seven 181.22 to 187.21 square foot partially covered outdoor modules are provided for D-Pod segregation which are equipped with a pullup bar. Three 183.12 to 187.74 square foot partially covered outdoor modules are provided for C2 segregation.

Multi-purpose rooms are also located throughout the facility and in each housing area to facilitate programs, including arts and crafts. The latest movie releases are shown on the weekends and holidays. The popular soccer fields were removed with the recent addition of four new housing units.

Religious Programming:

(b)(6); (b)(7)(C)

Otay Mesa Detention Center religious and volunteer services are planned, directed, and coordinated by two full-time chaplains. Chaplain [redacted] has a Certificate of License and Endorsement by Halbert Baptist and Certificate of Commission by Church of God in Christ. Chaplain (b)(6); (b)(7)(C) has a bachelor's degree in Master of Divinity, is endorsed by Christian Faith, has a half unit of Clinical Pastoral Education under auspices of the ACPE, Inc., and Pastoral Care Specialist Certificate. Local churches and volunteers assist in the delivery of a variety of religious and social services programs. At the time of the visit, there were 42 approved volunteers on the list. Volunteers are screened and provided eight hours orientation and initial training and four hours refresher training each year. A large multi-purpose room serves as the chapel for as many as 400 religious services and study programs; four classrooms are also available if needed. The Interfaith Service Schedule offers worship, study, counseling, and fellowship times in which all detainees may participate seven days a week. The chaplains visit the segregation units regularly. The chaplains maintain a library of books and materials that are available to the detainees, and they maintain contact with outside organizations for resources and donations. Religious diets are reviewed and approved by the chaplains. The chaplains process marriage requests, and also assist in the notification of incidents or deaths to the detainees. Religious groups/ministries on the schedule include Roman Catholic, Christian, Protestant, and Jehovah Witness. The chaplains make every effort to recruit volunteers for requested religious faiths. The visiting committee observed a large group of detainees participating in the Nancy, Victor, and Tango interfaith program on Monday.

AMERICAN OVERSIGHT

Offender Work Programs:

Federal detainees are not required to work based on contractual requirements; however, they are expected to keep their housing areas clean. Many detainees do volunteer for work assignments by submitting an application to unit staff. Work assignments are limited to inside jobs such as porter in many areas, kitchen, laundry, barber, commissary, education, library, etc. Food service workers earn $1.50 a day and all other assignments earn $1.00 a day. Written job descriptions were available, and safety training and equipment is provided. During the visit, 696 detainees were volunteering for work assignments.

Academic and Vocational Education:

The nature of the population, the restrictions on access to programs, and the short average time they remain here, combined, eliminate most reasonable opportunities for traditional programs found in other local facilities. In spite of the barriers, staff continues to develop specific programs that do target detainee population needs and also have some potential to be addressed in very short time frames. Sixteen Life Skills Programs were being offered (listed under social services) during the visit, and in August 2019, Grossmount College began offering HISET (High School Equivalency Test) to US Marshal detainees. HISET classes are held in four classrooms, and 30 females and 45 males were participating during the visit.

Otay Mesa Detention Center has over 60 different nationalities with a large Latino population that frequently does not speak English. Spanish is the major non-English language spoken by 40% of the detainee population. On November 12, 2019, Grossmount College began offering English as a Second Language classes (ESL) for US Marshal detainees. A language line is available and is frequently utilized for translation; 160 staff spoke Spanish at the time of the visit.

The HISET and ESL programs are funded through a state grant; therefore, there is no cost to the detainees.

Social Services:

Provision of social services programs are not a significant mission of OMDC due to the specialized nature of the population and the focus of the contracts by ICE and the USMS. Even programs of relatively short duration are often too long for many detainees to accomplish in their short stay, so the facility leadership and staff has focused on programs that target common detainee deficits that can be delivered quickly. As part of social services, mental health personnel provides individual counseling and crisis intervention; Grossmount College provides a HISET and English as a Second Language Program; and chaplains and community volunteers provide study groups, spiritual counseling, and visits. Services are available seven days a week and are posted in all housing units.

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The 16 Life Skills Programs, delivered primarily in the housing units, do give the detainees an opportunity to learn coping skills that they may lack and that can also help to deal with current stresses they are facing. The programs last four to six weeks and are facilitated by the unit teams. The programs are rotated so they are all not offered at the same time. Seventy-five detainees were enrolled in Life Skills Programs during the visit.

1. Understanding and Reducing Anger Feelings
2. Ideas for Better Communication
3. Building a Social Network
4. Unlock Your Thinking
5. Common Sense HI Prevention
6. Approaches to HIV-AIDS Prevention
7. Partners in Parenting
8. Mapping Your Steps
9. Straight Ahead Transition Skills
10. Time Out for Men
11. Time Out for Me
12. Mapping a New Roads to Recovery
13. Mapping the Journey
14. Preparation for Change
15. Mapping Your Reentry Plan
16. 12 Step AA/NA

Visitation:

Otay Mesa Detention Center recognizes the importance of visits; therefore, many opportunities are offered on the posted schedule. Video visitation is scheduled seven days a week between 8:30 a.m. to 10:30 a.m., 1:00 p.m. to 3:00 p.m., and 5:00 p.m. to 7:00 p.m. Contact Visitation is scheduled on Saturday and Sunday between 7:00 a.m. to 7:15 p.m. Visits are a minimum of one hour, and only four visitors are allowed per visit, including children.

Contact visiting is located on the second floor in the administration building. One large contact visiting room provides space for up to 217. This area only includes a water fountain, restrooms, and seating. Seven attorney visitation rooms, three asylum interview rooms, one asylum interview room with for telephonic rooms, and five court rooms are also located on the second floor. The general public video visitation area is located in the lobby area of the administration building and provides 20 video visiting stations. Video visitation areas are located in each housing unit/pod for detainees.

Visitation for U.S. Marshal detainees is non-contact and is conducted by in-house video stations. U.S. Marshal detainees may be approved on a case-by-case basis for a special visit for families traveling over 250 miles one way.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001333

ICE detainees may qualify for contact visitation if the visitor is approved by the ICE screening process, and if requested at least ten days in advance.

Library Services:

(b)(7)(E) library aides provide oversight over the general library and law library; the library space maximum capacity is 70. The library is open Monday through Friday from 5:05 a.m. to 9:25 p.m. Two soft cover books can be checked out for one week; hard cover books can only be viewed in the library. The library contains approximately 3,000 books, which includes a Spanish section. Book carts are located in the segregation units and medical infirmary and books are rotated out on Tuesday. Detainees can purchase publications from a recognized publisher, distributor, or authorized retailer. The visiting committee observed books in cells and dorms throughout the facility.

The main law library provides 12 computer stations with the Lexis Nexis program; a set of law books were also available. Each pod also has two computer stations, and segregation has one. Detainees can sign up for time in the main law library or the pod law library. Attorney phone calls are arranged with the unit staff. Photocopying, printing services, and computer assistance is available for detainees through the library staff in the main library.

Laundry:

The Otay Mesa Detention Center laundry is staffed with (b)(7)(E) and 16 detainees (b)(7)(E) Monday through Friday, 16 hours a day. Clothing, bedding, and personal hygiene are issued at intake. Detainees receive three sets of clothing and five sets of underclothes. ICE detainees wear blue, orange, or red dependent on their level; USMS detainees wear brown uniforms; and kitchen workers wear white uniforms. Every housing unit/detainee is scheduled to have their clothing and linen laundered two times a week. Blankets are laundered once a month. The laundry schedule is posted in the housing units. Equipment consists of six 165 pound and one 45 pound commercial washers, eight 165 pound commercial dryers, and one sewing machine. It was reported that lint traps are checked after every load. The chemicals are automatically dispensed to the washers from secured bulk containers. Chemicals were controlled and inventoried, an eyewash station was available, and SDS and personal protective equipment were in place. Mattress sanitizing is conducted in the intake area.

Community Relations

Otay Mesa Detention Center staff is actively involved in community organizations. It was reported that every year, a TOYS for TOTS toy drive is held collecting toys for underprivileged children in San Diego County.

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Patriot Packets, a collection of donated items, are currently being collected for deployed service members in the CoreCivic family. OMDC also participates in "Light the Night Against Crime," an annual event held by a non-profit organization, San Diego Crime Stoppers, focused on reducing crime in their community.

OMDC continues their involvement with STAR PAL, a San Diego based non-profit organization committed to empowering underserved youth in the community to build a safer and harmonious relationship with law enforcement. Staff recently participated in the 19th Annual Superheroes for Youth Celebrity Waiter Luncheon where local celebrities teamed up with local law enforcement to raise money for the organization. CoreCivic is currently a platinum superhero sponsor. The 2019 successful event grossing over $170,000 for STAR/PAL youth programs, providing inner-city and at-risk youth with positive experiences and critical programming led by law enforcement officers.

F. Examination of Records

Following the facility tour, the team proceeded to the warden's conference room to review the paper accreditation files and evaluate compliance levels of the policies and procedures. The Otay Mesa Detention Center utilizes CoreCivic policies and some OMDC facility policies and directives in the files. Accreditation files were organized, uniform, and easy to go through; very few files required additional documentation.

A review of six detainee case records (3 ICE/3 USMS) revealed uniformity and thorough documentation. Five staff personnel files were also reviewed; documentation was organized, complete, and medical records were maintained separately. Access is limited and files were maintained in a secure location.

The chairperson reviewed the January 23-25, 2019, Annual Detention Inspection of the OMDC, which was conducted by a team of contracted subject matter experts from the Nakamoto Group, Inc. The review was based on the ICE Performance-Based National Detention Standards. A final rating of "Meets Standard" was assigned. The chairperson met with (b)(6); (b)(7)(C) ICE Contract Monitor to discuss the January audit, his role at the facility, and the collaboration with OMDC staff (b)(6); (b)(7)(C) reported that he has a good working relationship with the OMDC staff, and any identified deficiencies are quickly resolved. He stated he was very fortunate to work with such a great group of staff the last five years.

The chairperson reviewed the May 14-16, 2019, OMDC Quality Assurance Review (QAR), which was conducted by a team of contracted subject matter experts from the Nakamoto Group, Inc. The QAR utilized the Federal Performance-Based Detention Standards for non-federal detention facilities, which provided the United States Marshal Service a comprehensive overview of the OMDC operations. The overall facility operation received a rating of "Marginal." The chairperson met with (b)(6); (b)(7)(C) USMS Contract Monitor to discuss the May audit, her role at the facility, and the collaboration with OMDC staff.

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(b)(6); (b)(7)(C) also reported that she has a good working relationship with OMDC staff, and any identified deficiencies are quickly resolved. She agreed that the staff and detainee morale was good and there is an open line of communication between the two.

The facility had zero notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

Over the last three years, the facility had zero consent decrees, class action lawsuits or adverse judgments; however, there are several pending lawsuits involving detainees and staff.

2. Significant Incidents/Outcome Measures

The visiting committee reviewed and discussed the Otay Mesa Detention Center Significant Incident Summary for the period of October 2018 through September 2019. The numbers reflected in the report are consistent with the overall mission and security level of the facility. There were 62 offender/offender assaults and 29 offender/staff assaults reported; only five were with a weapon (three detainee/employee), and none required outside medical treatment.

The medical auditor reviewed the Healthcare Outcome Measures with the health care administrative team; the numbers were consistent with the custody level and detainees being housed.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Administration	(b)(6); (b)(7)(C)
Chaplain	
Contract Monitors	
Human Resources	
Fire Safety	
Mailroom	

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Maintenance Medical	(b)(6); (b)(7)(C)
Records Security	
Unit Management	

4. Shifts

OMDC schedules its detention officers on one of three 8-hour shifts with a 15 minute briefing prior to each shift. An administrative shift is assigned Monday through Friday.

a. Day Shift 7:00 a.m. to 3:30 p.m.

The team was present at the facility during the day shift on Monday, Tuesday, and Wednesday. Most of this shift was spent touring the facility; speaking to department supervisors, staff, and detainees; verifying protocols; observing counts; checking key, tool, caustic and chemical control; and assessing conditions of confinement. Staff was observed performing their duties in a professional manner and detainees were observed working, enjoying recreation and leisure time, and a religious group. Staff members were very knowledgeable concerning their duties and responsibilities, and the morale was good. Serving of the lunch meal was observed and sampled, and an auditor observed the distribution of medications.

b. Swing Shift 3:00 p.m. to 11:30 p.m.

The team was present at the facility during the swing shift Monday and Tuesday. The team had the opportunity to speak with staff at their posts and observe afternoon recreation and leisure time.

c. Graveyard Shift 11:00 p.m. to 7:30 a.m.

The team was present at the facility during the graveyard shift from 10:45 to 11:30 p.m. Monday night. Oncoming officers cleared the metal detector and personal belongings were inspected.

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Two team members had the opportunity to speak with the oncoming officers, and one team member (b)(7)(E) observed the perimeter to be well lit. The shift roster identified (b)(7)(E) (b)(7)(E)

5. Status of Previously Non-compliant Standards/Plans of Action

Not Applicable.

G. Interviews

During the course of the audit, team members met with both staff and detainees to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interviews

The team spoke with approximately 57 detainees during the course of the audit. The most common refrain of those who were interviewed was the stress of the uncertainty about their future and probable deportation. Their comments about the facility and staff were positive and indicated no major concerns about safety or security. One unit cheered on an officer as he was ending his shift, and many praised him for doing a great job in the unit. Positive comments about food and sanitation were received from all detainees the team met. Questions were asked regarding food, medical care, programs, grievances, fire drills, safety, quality of life, and other basic services at the facility. Detainees all stated they felt safe in their environment. The warden shared a letter from a detainee who had been released. The detainee expressed his gratitude to the staff for believing in him and helping him while incarcerated at OMDC.

2. Staff Interviews

Approximately 98 staff members were interviewed by the visiting committee. It was apparent that the staff had been informed of the audit and prepared for the visit. The team felt that each employee displayed a high level of professionalism and pride. All staff stated that they enjoyed working at the facility, they felt that they were well compensated and that they had a good benefits package, the training received is pertinent to the job, and they felt safe in their working environment. They stated that the executive staff was very responsive to any and all of their concerns and Warden LaRose is open to new ideas. Many correctional officers did discuss all the overtime they have to work, and they are hoping it will slow down soon.

H. Exit Discussion

The exit interview was held at 10:30 a.m. in a training room with Warden Christopher LaRose and 60 Otay Mesa Detention Center staff in attendance.

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The following persons from outside the facility were also in attendance:

(b)(6); (b)(7)(C)

The chairperson expressed appreciation for the hospitality and cooperation of everyone involved. The team reviewed their individual findings with the group and discussed the compliance levels of the mandatory and non-mandatory standards. Although staff has been faced with overtime challenges, they are working together, as a team, to meet contract requirements and the CoreCivic Mission. At the end of the day both staff and detainees said they felt safe. Staff was commended for their hard work and dedication to the accreditation process.

The chairperson explained that the audit team is the eyes and ears of the commission, and the Commission on Accreditation for Corrections determines and awards accreditation at the scheduled panel hearing. The procedures that follow the audit were explained.

The chairperson again thanked and congratulated the Otay Mesa Detention Center staff for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field as they begin their new audit cycle.

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AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Adult Local Detention Facilities, 4th Edition	
Supplement	2016 Standards Supplement	
Facility/Program	Otay Mesa Detention Center	
Audit Dates	November 11 - 13, 2019	
Auditor(s)	(b)(6); (b)(7)(C) , Chairperson Member ealthcare Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	60	323
Number Not Applicable	0	29
Number Applicable	60	294
Number Non-Compliance	0	0
Number in Compliance	60	294
Percentage (%) of Compliance	100%	100%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

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COMMISSION ON ACCREDITATION FOR CORRECTIONS

Core Civic
Otay Mesa Detention Center
San Diego, California

November 11 - 13, 2019

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-ALDF-1A-09

REVISED AUGUST 2008. SINGLE CELLS IN GENERAL POPULATION PROVIDE AT LEAST 35 SQUARE FEET OF UNENCUMBERED SPACE. AT LEAST 70 SQUARE FEET OF TOTAL FLOOR SPACE IS PROVIDED WHEN THE OCCUPANT IS CONFINED FOR MORE THAN 10 HOURS PER DAY.

FINDINGS:

Otay Mesa Detention Center does not have single cells for general population.

Standard #4-ALDF-1A-15

REVISED AUGUST 2006 (EXISTING ONLY) ALL INMATE ROOMS/CELLS PROVIDE THE OCCUPANTS WITH ACCESS TO NATURAL LIGHT.

FINDINGS:

Otay Mesa Detention Center was constructed in 2015; new construction of 4 housing units was complete in October 2019. The facility falls under new construction "plans approved after January 1, 1990," therefore, this standard does not apply. Standard 4-ALDF-1A-16 was applied for access to natural light.

Standard #4-ALDF-2A-36

INMATES PARTICIPATING IN WORK OR EDUCATIONAL RELEASE PROGRAMS ARE SEPARATED FROM INMATES IN THE GENERAL POPULATION.

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DHS-ICE-20-0618-A-001341

FINDINGS:

Otay Mesa Detention Center detainees are not allowed to participate in work or educational release programs.

Standard #4-ALDF-2A-37

REVISED AUGUST 2008. CONFINEMENT OF JUVENILES UNDER THE AGE OF 18 IS PROHIBITED UNLESS A COURT FINDS THAT IT IS IN THE BEST INTEREST OF JUSTICE AND PUBLIC SAFETY THAT A JUVENILE AWAITING TRIAL OR OTHER LEGAL PROCESS BE TREATED AS AN ADULT FOR THE PURPOSE OF PROSECUTION, OR UNLESS CONVICTED AS AN ADULT AND REQUIRED BY STATUTE TO BE CONFINED IN AN ADULT FACILITY.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

Standard #4-ALDF-2A-38

IF YOUTHFUL OFFENDERS ARE HOUSED IN THE FACILITY, THEY ARE HOUSED IN A SPECIALIZED UNIT FOR YOUTHFUL OFFENDERS EXCEPT WHEN:

VIOLENT, PREDATORY YOUTHFUL OFFENDER POSES AN UNDUE RISK OF HARM TO OTHERS WITHIN THE SPECIALIZED UNIT, OR
A QUALIFIED MEDICAL OR MENTAL-HEALTH SPECIALIST DOCUMENTS THAT THE YOUTHFUL OFFENDER WOULD BENEFIT FROM PLACEMENT OUTSIDE THE UNIT

A WRITTEN STATEMENT IS PREPARED DESCRIBING THE SPECIFIC REASONS FOR HOUSING A YOUTHFUL OFFENDER OUTSIDE THE SPECIALIZED UNIT AND A CASE-MANAGEMENT PLAN SPECIFYING WHAT BEHAVIORS NEED TO BE MODIFIED AND HOW THE YOUTHFUL OFFENDER MAY RETURN TO THE UNIT. THE STATEMENT OF REASONS AND CASE-MANAGEMENT PLAN MUST BE APPROVED BY THE FACILITY ADMINISTRATOR OR HIS/HER DESIGNEE. CASES ARE REVIEWED AT LEAST QUARTERLY BY THE CASE MANAGER, THE ADMINISTRATOR OR HIS OR HER DESIGNEE, AND THE YOUTHFUL OFFENDER TO DETERMINE WHETHER A YOUTHFUL OFFENDER SHOULD BE RETURNED TO THE SPECIALIZED UNIT.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001342

Standard #4-ALDF-2A-39

DIRECT SUPERVISION IS EMPLOYED IN THE SPECIALIZED UNIT TO ENSURE THE SAFETY AND SECURITY OF YOUTHFUL OFFENDERS.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

Standard #4-ALDF-2A-40

CLASSIFICATION PLANS FOR YOUTHFUL OFFENDERS DETERMINE LEVEL OF RISK AND PROGRAM NEEDS DEVELOPMENTALLY APPROPRIATE FOR ADOLESCENTS. CLASSIFICATION PLANS INCLUDE CONSIDERATION OF PHYSICAL, MENTAL, SOCIAL, AND EDUCATIONAL MATURITY OF THE YOUTHFUL OFFENDER.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

Standard #4-ALDF-2A-41

REVISED AUGUST 2008. ADEQUATE PROGRAM SPACE IS PROVIDED TO MEET THE PHYSICAL, SOCIAL, AND EMOTIONAL NEEDS OF YOUTHFUL OFFENDERS AND ALLOWS FOR THEIR PERSONAL INTERACTIONS AND GROUP ORIENTED ACTIVITIES.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

Standard #4-ALDF-2A-42

REVISED AUGUST 2008. YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT FOR YOUTHFUL INMATES HAVE NO MORE THAN INCIDENTAL SIGHT OR SOUND CONTACT WITH ADULT INMATES FROM OUTSIDE THE UNIT IN LIVING, PROGRAM, DINING, OR OTHER COMMON AREAS OF THE FACILITY. ANY OTHER SIGHT OR SOUND CONTACT IS MINIMIZED, BRIEF, AND IN CONFORMANCE WITH APPLICABLE LEGAL REQUIREMENTS.

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001343

Standard #4-ALDF-2A-43

REVISED AUGUST 2008. PROGRAM PERSONNEL WHO WORK WITH YOUTHFUL OFFENDERS ARE TRAINED IN THE DEVELOPMENTAL, SAFETY, AND OTHER SPECIFIC NEEDS OF YOUTHFUL OFFENDERS. WRITTEN JOB DESCRIPTIONS AND QUALIFICATIONS REQUIRE TRAINING FOR STAFF WHO ARE RESPONSIBLE FOR PROGRAMMING OF YOUTHFUL OFFENDERS IN THE SPECIALIZED UNIT BEFORE BEING ASSIGNED TO WORK WITH YOUTHFUL OFFENDERS. TRAINING INCLUDES, BUT IS NOT LIMITED TO THE FOLLOWING AREAS:

- ADOLESCENT DEVELOPMENT
- EDUCATIONAL PROGRAMMING
- CULTURAL AWARENESS
- CRISIS PREVENTION AND INTERVENTION
- LEGAL ISSUES
- HOUSING AND PHYSICAL PLANT
- POLICIES AND PROCEDURES
- MANAGEMENT OF, AND PROGRAMMING FOR, SEX OFFENDERS
- SUBSTANCE-ABUSE SERVICES
- COGNITIVE BEHAVIORAL INTERVENTIONS, INCLUDING ANGER MANAGEMENT, SOCIAL-SKILLS TRAINING, PROBLEM SOLVING
- RESISTING PEER PRESSURE
- SUICIDE PREVENTION
- NUTRITION
- MENTAL-HEALTH ISSUES
- GENDER-SPECIFIC ISSUES
- CASE-MANAGEMENT PLANNING AND IMPLEMENTATION

FINDINGS:

Otay Mesa Detention Center does not house juvenile inmates/detainees.

Standard #4-ALDF-2C-02

WHEN A CANINE UNIT IS OPERATED BY THE FACILITY:

1. THERE IS A MISSION STATEMENT, INCLUDING GOALS AND OBJECTIVES;
2. THE CIRCUMSTANCES IN WHICH CANINE UNITS MAY BE USED ARE CLEARLY DEFINED;
3. EMERGENCY PLANS ARE INTEGRATED INTO THE OVERALL EMERGENCY PLANS OF THE FACILITY;
4. THERE ARE CRITERIA FOR SELECTING, TRAINING AND CARING FOR ANIMALS;

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DHS-ICE-20-0618-A-001344

5. THERE ARE CRITERIA FOR THE SELECTION, TRAINING, AND PHYSICAL FITNESS OF HANDLERS;
6. THERE IS AN APPROVED SANITATION PLAN THAT COVERS INSPECTION, HOUSING, TRANSPORTATION AND DAILY GROOMING FOR THE ANIMALS; AND THERE ARE DAILY AND CURRENT RECORDS ON TRAINING, CARE OF DOGS AND SIGNIFICANT EVENTS.

FINDINGS:

Otay Mesa Detention Center does not have a canine unit. Canine services are provided by the Border Patrol Agents stationed in San Diego, if needed.

Standard #4-ALDF-4A-14

WHEN REQUIRED BY STATUTE, FOOD PRODUCTS THAT ARE GROWN OR PRODUCED WITHIN THE SYSTEM ARE INSPECTED AND APPROVED BY THE APPROPRIATE GOVERNMENT AGENCY; THERE IS A DISTRIBUTION SYSTEM THAT ENSURES PROMPT DELIVERY OF FOODSTUFFS TO FACILITY KITCHENS.

FINDINGS:

Otay Mesa Detention Center does not grow or produce any food products for use in the kitchen.

Standard #4-ALDF-5A-04

INMATES WITH DRUG AND ALCOHOL ADDICTION PROBLEMS ARE PROVIDED WITH SUBSTANCE ABUSE PROGRAMS, TO INCLUDE MONITORING AND DRUG TESTING.

FINDINGS:

Conventional substance abuse programs found in longer-term detention operations for normal local populations are not feasible here. This pre-trial population of illegal aliens serves an average of 83 days in the facility, followed by deportation or a rare release with little or no notice.

Otay Mesa Detention Center does not offer a substance program. The ICE contract does not require drug testing. The USMS contract requires random drug testing on 5% of detainees monthly.

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Standard #4-ALDF-5A-05

THERE IS A TREATMENT PHILOSOPHY WITHIN THE CONTEXT OF THE TOTAL CORRECTIONAL SYSTEM AS WELL AS GOALS AND MEASURABLE OBJECTIVES. THESE DOCUMENTS ARE REVIEWED AT LEAST ANNUALLY AND UPDATED AS NEEDED.

FINDINGS:

This pre-trial population of illegal aliens does not permit a significant treatment philosophy since most detainees will be deported in a very short time due to their illegal status.

Otay Mesa Detention Center does have measurable goals and objectives, primarily of a safety and security nature, and they are reviewed annually.

Standard #4-ALDF-5A-06

THERE IS AN APPROPRIATE RANGE OF PRIMARY TREATMENT SERVICES FOR ALCOHOL AND OTHER SUBSTANCE-ABUSING INMATES THAT INCLUDE, AT A MINIMUM, THE FOLLOWING:

- INMATE DIAGNOSIS
- IDENTIFIED PROBLEM AREAS
- INDIVIDUAL TREATMENT OBJECTIVES
- TREATMENT GOALS
- COUNSELING NEEDS
- DRUG EDUCATION PLAN
- RELAPSE PREVENTION AND MANAGEMENT
- CULTURALLY SENSITIVE TREATMENT OBJECTIVES, AS APPROPRIATE
- THE PROVISION OF SELF-HELP GROUPS AS AN ADJUNCT TO TREATMENT
- PRERELEASE AND TRANSITIONAL SERVICE NEEDS
- COORDINATION EFFORTS WITH COMMUNITY SUPERVISION AND TREATMENT STAFF DURING THE PRERELEASE PHASE TO ENSURE A CONTINUUM OF SUPERVISION AND TREATMENT.

FINDINGS:

Conventional substance abuse programs found in ALDF operations for normal local populations are not feasible here. This pre-trial population of illegal aliens serves an average of 83 days in the facility, followed by deportation or a rare release with little or no notice.

Defining longer-term treatment or relapse prevention needs, and providing pre-release preparation and coordination with the community, is not practicable or feasible.

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Otay Mesa Detention Center does not offer a substance program. The ICE contract does not require drug testing. The USMS contract requires random drug testing on 5% of detainees monthly.

Standard #4-ALDF-5A-07

THE FACILITY USES A COORDINATED STAFF APPROACH TO DELIVER TREATMENT SERVICES. THIS APPROACH TO SERVICE DELIVERY IS DOCUMENTED IN TREATMENT PLANNING CONFERENCES AND IN INDIVIDUAL TREATMENT FILES.

FINDINGS:

Treatment planning conferences and development of individual treatment files are impractical within the normal 83-day average stay. The nature of the population and their potential issues mandate that staffing coordination focus on threat groups, criminal gang affiliations and potential terrorist identification to ensure safety of the facility, staff, and detainees.

Standard #4-ALDF-5A-08

THERE ARE INCENTIVES FOR TARGETED TREATMENT PROGRAMS TO INCREASE AND MAINTAIN THE INMATE'S MOTIVATION FOR TREATMENT.

FINDINGS:

This very short-term illegal alien population has inadequate time for treatment during the average 83-day stay, so there are no incentives and no targeted treatment.

Standard #4-ALDF-5B-13

ALL INMATES HELD FOR 30 OR MORE DAYS WHO WILL BE RELEASED TO THE COMMUNITY ARE PROVIDED WITH PREPARATION FOR RELEASE THAT INCLUDES INFORMATION ABOUT COMMUNITY RESOURCES.

FINDINGS:

Virtually every detainee is deported; release to the community is extremely rare and unpredictable. A prerelease preparation program is not viable in this facility.

Standard #4-ALDF-5B-14

WHEN THE FACILITY IS DESIGNATED TO OPERATE ANY TYPE OF PRETRIAL INTERVENTION SERVICE OR OTHER RELEASE PROGRAMS, ITS AUTHORITY AND RESPONSIBILITY ARE STATED BY STATUTE OR ADMINISTRATIVE REGULATION.

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FINDINGS:

The Otay Mesa Detention Center population cannot qualify to use pretrial intervention or release programs but can seek assistance to apply for asylum.

Standard #4-ALDF-5B-15

WHEN A PRETRIAL INTERVENTION PROGRAM, DIVERSION PROGRAM, PRETRIAL RELEASE PROGRAM, OR SUPERVISED RELEASE PROGRAM IS CONDUCTED IN THE FACILITY, SUFFICIENT STAFF, SPACE, AND EQUIPMENT ARE PROVIDED TO SERVICE THE PROGRAM.

FINDINGS:

The Otay Mesa Detention Center does not conduct a pretrial intervention, diversion, pretrial release, or supervised release program due to the type of detainees housed.

Standard #4-ALDF-5B-16

WHERE TEMPORARY RELEASE PROGRAMS EXIST, THE PROGRAMS HAVE THE FOLLOWING ELEMENTS:

WRITTEN OPERATIONAL PROCEDURES
CAREFUL SCREENING AND SELECTION PROCEDURES
WRITTEN RULES OF INMATE CONDUCT
A SYSTEM FOR EVALUATING PROGRAM EFFECTIVENESS
EFFORTS TO OBTAIN COMMUNITY COOPERATION AND SUPPORT

FINDINGS:

The Otay Mesa Detention Center does not offer a temporary release program.

Standard #4-ALDF-5B-17

WHERE WORK RELEASE AND/OR EDUCATIONAL RELEASE ARE AUTHORIZED, THE FACILITY ADMINISTRATOR HAS AUTHORITY TO APPROVE OR DISAPPROVE PARTICIPATION FOR EACH INMATE.

FINDINGS:

The Otay Mesa Detention Center policy and contracts do not allow for work or education release programs.

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Standard #4-ALDF-5C-07

THE FACILITY REQUIRES ALL SENTENCED INMATES TO WORK IF THEY ARE NOT ASSIGNED TO PROGRAMS.

FINDINGS:

Otay Mesa Detention center does not house sentenced inmates. ICE and USMS detainees are all pretrial and awaiting deportation. The contracts do not require detainees to work, but they may volunteer to work for minor reimbursement.

Standard #4-ALDF-5C-09

WHERE STATUTE PERMITS, INMATES ARE ASSIGNED TO PUBLIC WORKS AND COMMUNITY SERVICE PROJECTS.

FINDINGS:

Contract requirements do not permit community projects or work movement away from the facility.

Standard #4-ALDF-5C-13

WHERE AN INDUSTRIES PROGRAM EXISTS, ITS ESTABLISHMENT IS AUTHORIZED AND AREAS OF AUTHORITY, RESPONSIBILITY, AND ACCOUNTABILITY ARE DELINEATED.

FINDINGS:

The Otay Mesa Detention Center does not operate an industries program.

Standard #4-ALDF-5C-14

THE NUMBER OF INMATES ASSIGNED TO INDUSTRIES OPERATIONS MEETS THE REALISTIC WORKLOAD NEEDS OF EACH OPERATING UNIT.

FINDINGS:

The Otay Mesa Detention Center does not operate an industries program.

Standard #4-ALDF-5C-15

THERE IS A COMPREHENSIVE QUALITY CONTROL PROCESS.

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FINDINGS:

The Otay Mesa Detention Center does not operate an industries program.

Standard #4-ALDF-5C-16

A COST ACCOUNTING SYSTEM FOR EACH INDUSTRIES UNIT IS DESIGNED, IMPLEMENTED, AND MAINTAINED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.

FINDINGS:

The Otay Mesa Detention Center does not operate an industries program.

Standard #4-ALDF-7F-02

CONSISTENT WITH THE LAWS OF THE JURISDICTION, THERE IS A SYSTEM FOR PROVIDING NOTIFICATION TO THE REGISTERED VICTIM(S) OF A CRIME UPON THE RELEASE FROM CONFINEMENT OF THE CONVICTED INMATE OR IN THE EVENT OF AN ESCAPE. FOLLOW UP NOTIFICATION TO THE VICTIM(S) OCCURS WHEN ESCAPEES ARE RETURNED TO CUSTODY.

FINDINGS:

The Otay Mesa Detention Center population is illegal aliens and there is no victim notification program necessary or in effect.

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Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Otay Mesa Detention Center
Reporting Period: October 2018 – September 2019

Incident Type	Months →	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	July 2019	Aug 2019	Sept 2019	Total for Reporting
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	1	0	0	1
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	7	7	4	1	1	5	5	7	9	6	5	5	62
	Offender/ Staff	5	2	9	1	0	0	4	0	2	1	2	3	29
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		0	0	0	0	0	0	0	0	0	0	0	0	0

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

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Name of Facility: Otay Mesa Detention Center
Number of Months Data Collected: 12 (October 2018 through September 2019)

		ALDF Outcome Measure Worksheet		
1A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from injury and illness caused by the physical environment.**	**Value**	**Calculat-ed O.M**
	(1)	Number of worker compensation claims filed for injuries that resulted from the physical environment in the past 12 months.	58	
	divided by	Average number of Full-Time Equivalent (FTE) staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	1	
	divided by	Average daily population in the past 12 months.	1420	.0007
	(3)	Number of illnesses requiring medical attention as a result of the physical environment of the facility in the past 12 months.	1	
	divided by	The number of admissions in the past 12 months.	6812	.0001
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(5)	Number of physical injuries or emotional trauma requiring treatment as a result of the physical environment of the facility in the past 12 months.	0	
	divided by	The number of admissions in the past 12 months.	6812	0
	(6)	Number of sanitation or health code violations identified by external agencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(7)	Number of health code violations corrected in the past 12 months.	0	
	divided by	The number of health code violations identified in the past 12 months.	0	0
	(8)	Number of inmate grievances related to safety or sanitation found in favor of inmates in the past 12 months.	16	

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	divided by	The number of inmate's grievances related to safety or sanitation in the past 12 months.	0	.1875
	(9)	Number of fire code violations corrected in the past 12 months.	0	
	divided by	The number of fire code violations cited by jurisdictional authority in the past 12 months.	0	0
	(10)	Number of inmate injuries resulting from fires requiring medical treatment in a 12-month period.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(11)	Number of inmate injuries (other than by fire) requiring medical treatment in the past 12 months.	800	
	divided by	The average daily population of inmates in the past 12 months.	1420	.5633
	(12)	Number of staff injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population of staff in the past 12 months.	(b)(7)(E)	
	(13)	Number of staff injuries (other than fire) requiring medical treatment in the past 12 months.		
	divided by	The average daily population of staff in the past 12 months.		
	(14)	Number of inmate lawsuits related to safety or sanitation found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate lawsuits related to safety or sanitation in the past 12 months.	0	0
1B		**Vehicles are maintained and operated in a manner that prevents harm to the community, staff, contractors, volunteers, and inmates.**		
	(1)	Number of vehicle accidents resulting in property damage in the past 12 months.	4	
	divided by	The average daily population in the past 12 months.	1420	.0028
	(2)	Number of vehicle accidents resulting in injuries requiring medical treatment for any party in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(3)	Amount dollar of damage from vehicle accidents in the past 12 months.	2,397	
	divided by	The average daily population in the past 12 months.	1420	1.688

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1C		**The number and severity of emergencies are minimized. When emergencies occur, the response minimizes the severity.**		
	(1)	Number of emergencies, caused by forces external to the facility, that result in property damage in the past 12 months.	0	
	divided by	The number emergencies.	0	0
	(2)	Number of injuries, caused by forces external to the facility, requiring medical attention that resulted from emergencies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(3)	Number of times that normal facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(4)	Number of hours that facility operations were suspended due to emergencies caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies caused by forces external to the facility.	0	0
	(5)	Number of emergencies that were not caused by forces external to the facility that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(6)	Number of injuries requiring medical attention that resulted from emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	.0000
	(7)	Number of times that normal facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(8)	Number of hours that facility operations were suspended due to emergencies that were not caused by forces external to the facility in the past 12 months.	0	
	divided by	The number of emergencies.	0	0

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	(9)	Number of injuries resulting from fires requiring medical treatment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(10)	Number of fires that resulted in property damage in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(11)	Amount dollar of property damage from fire in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(12)	Number of code violations cited in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	0	0
	(13)	Number of incidents involving toxic or caustic materials in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(14)	Number of incidents of inventory discrepancies in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
2A	**Outcome Measure**	**Numerator/Denominator** **The community, staff, contractors, volunteers, and inmates are protected from harm. Events that pose risk of harm are prevented. The number and severity of events are minimized.**	**Value**	**Calculat-ed O.M**
	(1)	Number of incidents involving harm in the past 12 months.	24	
	divided by	The average daily population in the past 12 months.	1420	.0169
	(2)	Number of incidents in the past 12 months involving harm.	24	
	divided by	The number of admissions in the past 12 months.	6812	.0032
	(3)	Number of physical injuries or emotional trauma requiring treatment as a result of incidents in the past 12 months.	22	
	divided by	The average daily population in the past 12 months.	1420	.0154
	(4)	Number of physical injuries or emotional trauma requiring treatment as a result of the incidents in the past 12 months.	22	

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	divided by	The number of admissions in the past 12 months.	6812	.0032
	(5)	Number of unauthorized inmate absences from the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(6)	Number of instances of unauthorized access to the facility in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
2B		**Physical force is used only in instances of self-protection, protection of the inmate or others, prevention of property damage, or prevention of escape.**		
	(1)	Number of instances in which force was used in the past 12 months.	62	
	divided by	The average daily population in the past 12 months.	1420	.0436
	(2)	Number of instances in which force was used in the past 12 months.	62	
	divided by	The number of admissions in the past 12 months.	6812	.0091
	(3)	Number of times that staff use of force were found to have been inappropriate in the past 12 months.	5	
	divided by	The number of instances in which force was used.	62	.0806
	(4)	Number of inmate grievances filed alleging inappropriate use of force in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(5)	Number of grievances alleging inappropriate use of force decided in favor of inmate in the past 12 months.	0	
	divided by	The number of grievances alleging inappropriate use of force filed.	0	0
	(6)	Number of injuries requiring medical treatment resulting from staff use of force in the past 12 months.	6	
	divided by	The average daily population in the past 12 months.	1420	.0042
2C		**Contraband is minimized. It is detected when present in the facility.**		
	(1)	Number of incidents involving contraband in the past 12 months.	33	
	divided by	The average daily population in the past 12 months.	1420	.0232

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	(2)	Number of incidents involving contraband in the past 12 months.	33	
	divided by	The number of admissions in the past 12 months.	6812	.0048
	(3)	Number of weapons found in the facility in the past 12 months.	7	
	divided by	The average daily population in the past 12 months.	1420	.0049
	(4)	Number of controlled substances found in the facility in the past 12 months.	5	
	divided by	The average daily population in the past 12 months.	1420	.0035
	(5)	Number of controlled substances found in the facility in the past 12 months.	5	
	divided by	The number of admissions in the past 12 months.	6812	.0007
2D		**Improper access to and use of keys, tools and utensils are minimized.**		
	(1)	Number of incidents involving keys in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	.0000
	(2)	Number of incidents involving tools in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1420	.0007
	(3)	Number of incidents involving culinary equipment in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(4)	Number of incidents involving medical equipment and sharps in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
3A		**Inmates comply with rules and regulations.**		
	(1)	Number of rule violations in the past 12 months.	647	
	divided by	The average daily population in the past 12 months.	1420	.4556
	(2)	Number of assaults—inmate against inmate, inmate against staff in the past 12 months.	72	
	divided by	The average daily population in the past 12 months.	1420	.0507

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4A		**Food service provides a nutritionally balanced diet. Food service operations are hygienic and sanitary.**		
	(1)	Number of documented inmate illnesses attributed to food service operations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(2)	Number of inmate grievances about food service decided in favor of the inmate the past 12 months.	6	
	divided by	The number of inmate grievances about food service in the past 12 months.	65	.0923
	(3)	Number of violations cited by independent authorities for food service sanitation in the past 12 months.	0	
		Divided by number of violations cited by independent authorities in the past 12 months.	0	0
4B		**Inmates maintain acceptable personal hygiene practices.**		
	(1)	Inmate grievances regarding inmate access to personal hygiene decided in favor of the inmate in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1420	
	(2)	Number of inmate illnesses attributed to poor hygiene practices in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(3)	Number of inmates diagnosed with hygiene-related conditions (scabies, lice, or fungal infections) in the past 12 months.	45	
	divided by	The average daily population in the past 12 months.	1420	0.0316
	(4)	Number of inmate grievances related to hygiene found in favor of the inmate in the past 12 months.	1	
	divided by	The number of inmate grievances related to hygiene in the past 12 months.	2	.5
	(5)	Number of inmate lawsuits related to hygiene found in favor of the inmate in the past 12 months.	0	
	divided by	The number of inmate lawsuits related to hygiene in the past 12 months.	0	0

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4C		**Inmates maintain good health. Inmates have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner.**		
	(1)	Number of inmates with a positive tuberculin skin test in the past 12 months.	48	
	divided by	The number of admissions in the past 12 months.	6812	.0070
	(2)	Number of inmates diagnosed with active tuberculosis in the past 12 months.	27	
	divided by	The average daily population in the past 12 months.	1420	.0190
	(3)	Number of conversions to a positive tuberculin skin test in the past 12 months.	0	
	divided by	The number of tuberculin skin tests given in the past 12 months.	48	0
	(4)	Number of inmates with a positive tuberculin skin test who completed prophylaxis treatment for tuberculosis in the past 12 months.	1	
	divided by	The number of inmates with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months.	1	1
	(5)	Number of Hepatitis C positive inmates in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1420	.0007
	(6)	Number of HIV positive inmates in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1420	.0007
	(7)	Number of HIV positive inmates who are being treated with highly active antiretroviral treatment in the past 12 months.	1	
	divided by	The number of known HIV positive inmates in the past 12 months.	18	0.055
	(8)	Number of offenders with an individualized services/treatment plan for a diagnosed mental disorder (excluding sole diagnosis of substance abuse) at a given point in time.	34	
	divided by	The average daily population in the past 12 months.	1420	.239
	(9)	Number of inmate suicide attempts in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	1420	0

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	(10)	Number of inmate suicides in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(11)	Number of inmate deaths due to homicide in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(12)	Number of inmate deaths due to injuries in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	.0007
	(13)	Number of medically expected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(14)	Number of medically unexpected inmate deaths in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(15)	Number of inmate admissions to the infirmary (where available) in the past 12 months.	291	
	divided by	The average daily population in the past 12 months.	1420	.2049
	(16)	Number of inmate admissions to off-site hospitals in the past 12 months.	165	
	divided by	The average daily population in the past 12 months.	1420	.1161
	(17)	Number of inmates transported off-site (via an ambulance or correctional vehicle) for treatment of emergency health conditions in the past 12 months.	707	
	divided by	The average daily population in the past 12 months.	1420	.4978
	(18)	Number of inmate specialty consults completed in the past 12 months.	58	
	divided by	The number of specialty consults (on-site or off-site) ordered by primary health care provider (MD, NP, PA) in the past 12 months.	90	.6444
	(19)	Number of inmate grievances about access to health care services found in favor of the inmate in the past 12 months.	10	
	divided by	The number of inmate grievances about access to healthcare services in the past 12 months.	72	.1388

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	(20)	Number of inmate grievances related to the quality of health care found in favor of inmates in the past 12 months.	13	
	divided by	The number of inmate grievances related to the quality of health care in the past 12 months.	130	.1
	(21)	Number of inmates' lawsuits about access to healthcare services found in favor of inmates in the past 12 months.	0	
	divided by	The number of inmate's lawsuits about access to healthcare services in the past 12 months.	2	0
	(22)	Number of individual sick call encounters in the past 12 months.	1772	
	divided by	The average daily population in the past 12 months.	1420	1.2478
	(23)	Number of physician visits contacts in the past 12 months.	303	
	divided by	The average daily population in the past 12 months.	1420	.2133
	(24)	Number of individualized dental treatment plans in the past 12 months.	181	
	divided by	The average daily population in the past 12 months.	1420	.1274
	(25)	Number of hypertensive inmates enrolled in a chronic care clinic in the past 12 months.	181	
	divided by	The average daily population in the past 12 months.	1420	.1274
	(26)	Number of diabetic inmates enrolled in a chronic care clinic in the past 12 months.	36	
	divided by	The average daily population in the past 12 months.	1420	.0253
	(27)	Number of incidents involving pharmaceuticals as contraband in the past 12 months.	1	
	divided by	The average daily population in the past 12 months.	1420	.0007
	(28)	Number of cardiac diets received by inmates with cardiac disease in the past 12 months.	133	
	divided by	The number of cardiac diets prescribed in the past 12 months.	133	1
	(29)	Number of hypertensive diets received by inmates with hypertension in the past 12 months.	133	
	divided by	The number of hypertensive diets prescribed in the past 12 months.	133	1
	(30)	Number of diabetic diets received by inmates with diabetes in the past 12 months.	1	

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	divided by	The number of diabetic diets prescribed in the past 12 months.	1	1
	(31)	Number of renal diets received by inmates with renal disease in the past 12 months.	4	
	divided by	The number of renal diets prescribed in the past 12 months.	4	1
	(32)	Number of needle-stick injuries in the past 12 months.	1	
	divided by	The number of employees on average in the past 12 months.	477	.0020
	(33)	Number of pharmacy dispensing errors in the past 12 months.	6	
	divided by	The number of prescriptions dispensed by the pharmacy in the past 12 months.	42550	.0001
	(34)	Number of nursing medication administration errors in the past 12 months.	60	
	divided by	The number of medications administered in the past 12 months.	44582	.0013
4D		**Health services are provided in a professionally acceptable manner. Staff are qualified, adequately trained, and demonstrate competency in their assigned duties.**		
	(1)	Number of staff with lapsed licensure and/or certification in the past 12 months.	0	
	divided by	The number of licensed or certified staff in the past 12 months.	(b)(7)(E)	
	(2)	Number of new employees in the past 12 months who completed orientation training prior to undertaking job assignments.		
	divided by	The number of new employees in the past 12 months.		
	(3)	Number of employees completing in-service training requirements in the past 12 months.		
	divided by	The number of employees eligible in the past 12 months.		
	(4)	Number of MD staff who left employment in the past 12 months.		
	divided by	The number of authorized MD staff positions in the past 12 months.		
	(5)	Number of RN staff who left employment in the past 12 months.		
	divided by	The number of authorized RN staff positions in the past 12 months.		
	(6)	Number of LPN staff who left employment in the past 12 months.		

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	divided by	The number of authorized LPN staff positions in the past 12 months.	(b)(7)(E)	
	(7)	Number of medical records staff who left employment in the past 12 months.		
	divided by	The number of medical records staff positions in the past 12 months.		
	(8)	Number of alleged sexual misconduct incidents between staff and detainees in the past 12 months.	15	
	divided by	Average daily population in the past 12 months.	1420	.0105
	(9)	Number of alleged sexual misconduct incidents between volunteers and/or contract personnel and detainees in the past 12 months.	2	
	divided by	Average daily population in the past 12 months.	1420	.0014
	(10)	Number of confirmed sexual misconduct incidents between staff and detainees in the past 12 months.	1	
	divided by	Average daily population in the past 12 months.	1420	.0007
	(11)	Number of confirmed sexual misconduct incidents between volunteers and/or contact personnel and detainees in the past 12 months.	0	
	divided by	Average daily population in the past 12 months.	1420	.0007
	(12)	Number of detainees identified as high risk with a history of sexually assaultive behavior in the past 12 months.	390	
	divided by	Average daily population in the past 12 months.	1420	.2746
	(13)	Number of detainees identified as at risk for sexual victimization in the past 12 months.	474	
	divided by	Average daily population in the past 12 months.	1420	.3333
5A		**Inmates have opportunities to improve themselves while confined.**		
	(1)	Number of inmates who passed GED exams while confined in the past 12 months.	0	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0	0
	(2)	Total number of grade levels advanced by inmates in the past 12 months.	0	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0	0
	(3)	Number of certificates of vocational competency awarded to inmates in the past 12 months.	0	
	divided by	The number of inmates who were sentenced to the jail for 6 months or more in the past 12 months.	0	0
5B		**Inmates maintain ties with their families and the community.**		
		NONE		

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5C		**The negative impact of confinement is reduced.**		
		NONE		
6A		**Inmates' rights are not violated.**		
	(1)	Total number of inmate grievances in the past 12 months, regarding: (a) access to court; (b) mail or correspondence; (c) sexual harassment; (d) discipline; (e) discrimination; (f) protection from harm.	58	
	divided by	The average daily population in the past 12 months.	1420	.0408
	(2)	Number of inmate grievances (see [a] through [e] above) decided in favor of inmates in the past 12 months.	11	
	divided by	The total number of grievances filed in the past 12 months.	658	.0167
	(3)	Total number of inmate court suits alleging violation of inmate rights filed against the facility in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	1420	.0014
	(4)	Number of inmate court suits alleging violation of inmate rights decided in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate suits filed in the past 12 months.	4	.0000
6B		**Inmates are treated fairly.**		
	(1)	Number of inmate grievances regarding discrimination in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(2)	Number of inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months.	0	
	divided by	The total number of inmate grievances filed regarding discrimination in the past 12 months.	0	0
	(3)	Number of grievances resolved in favor of inmates in the past 12 months.	105	
	divided by	The average daily population in the past 12 months.	1420	.0739
	(4)	Number of grievances resolved in favor of inmates in the past 12 months.	105	
	divided by	The total number of inmate grievances filed in the past 12 months.	658	.1595

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	(5)	Number of court malpractice or torte liability cases found in favor of the inmate in the past 12 months.	0	
	divided by	The number of court malpractice or torte liability cases in the past 12 months.	0	0
6C		**Alleged rule violations are handled in a manner that provides inmates with appropriate procedural safeguards.**		
	(1)	Number of disciplinary incidents resolved informally in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(2)	Number of formal inmate disciplinary decisions that were appealed in the past 12 months.	53	
	divided by	The total number of disciplinary decisions made in the past 12 months.	780	.0679
	(3)	Number of appealed disciplinary decisions decided in favor of the inmate in the past 12 months.	5	
	divided by	The total number of disciplinary decisions made in the past 12 months.	780	.0064
	(4)	Number of grievances filed by inmates challenging disciplinary procedures in the past 12 months.	2	
	divided by	The average daily population in the past 12 months.	1420	.0014
	(5)	Number of disciplinary-related grievances resolved in favor of the inmate in the past 12 months.	5	
	divided by	The total number of disciplinary-related grievances filed in the past 12 months.	30	.1666
	(6)	Number of court suits filed against the facility regarding discipline in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(7)	Number of court cases regarding discipline decided against the facility in the past 12 months.	0	
	divided by	The total number of court decisions regarding discipline decided in the past 12 months.	0	0
	(8)	Number of rule violations in the past 12 months.	780	
	divided by	The average daily population in the past 12 months.	1420	.4401
	(9)	Number of inmates terminated from the facility due to rule violations in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
6D		**Inmates take responsibility for their actions.**		

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	(1)	Number of inmates released in the past 12 months who made regular payments toward their restitution obligations.	0	
	divided by	The number of inmates who had restitution obligations in the past 12 months.	0	0
	(2)	Number of inmates who satisfy their court cost/fines obligations in the past 12 months.	0	
	divided by	The number of inmates who had court cost/fine obligations in the past 12 months.	0	0
	(3)	Total amount of restitution paid by inmates in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(4)	Total number of hours of community service donated by inmates in the past 12 months.	0	
	divided by	The average daily population in the past 12 months.	1420	0
	(5)	Total number of inmates who participated in restitution in the past 12 months.	0	
	divided by	The total number of inmates housed in the past 12 months.	8183	0
	(6)	Total number of inmates who participated in community service work in the past 12 months.	0	
	divided by	The total number of inmates housed in the past 12 months.	8183	0
	(7)	Total number of inmates who participated in victim awareness programs in the past 12 months.	0	
	divided by	The total number of inmates housed in the past 12 months.	8183	0
	(8)	Total amount of restitution paid by inmates in the past 12 months.	0	
	divided by	The total number of inmates housed in the past 12 months	8183	0
	(9)	Total number of hours delivered by inmates who participated in community service work in the past 12 months.	0	
	divided by	The total number of inmates housed in the past 12 months.	8183	0
7A		**The facility operates as a legal entity.**		
		NONE		
7B		**Staff, contractors, and volunteers demonstrate competency in their assigned duties.**		
	(1)	Total number of years of staff members' education as of the end of the last calendar year.	4112	

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	divided by	The number of staff at the end of the last calendar year.	(b)(7)(E)	
	(2)	Number of staff who left employment for any reason in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
	(3)	Total number of credit hours in course relevant to their facility responsibilities earned by staff participating in higher education in the past 12 months.	0	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(4)	Number of professional development events attended by staff in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
7C		**Staff, contractors, and volunteers are professional, ethical and accountable.**		
	(1)	Number of incidents in which staff was found to have acted in violation of facility policy in the past 12 months.	78	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of staff terminated for conduct violations in the past 12 months.		
	divided by	The number of full-time equivalent staff positions in the past 12 months.		
	(3)	Number of inmate grievances attributed to improper staff conducts which were upheld in the past 12 months.	2	
	divided by	The number of inmate grievances alleging improper staff conduct filed in the past 12 months.	2	1
	(4)	Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months.	2	
	divided by	The average daily population for the past 12 months.	1420	
	(5)	Where staff is tested, the number of staff substance abuse tests failed in the past 12 months.	0	
	divided by	The number of staff substance abuse tests administered in the past 12 months.	0	0
	(6)	Number of staff terminations for violation of drug-free work policy in the past 12 months.	0	
	divided by	The number of staff terminations in the past 12 months.	(b)(7)(E)	

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	(7)	The average number of physicians employed in the past 12 months.	(b)(7)(E)	
	divided by	The number of physician positions authorized in the past 12 months.		
	(8)	The average number of nurses employed in the past 12 months.		
	divided by	The number of nurse positions authorized in the past 12 months.		
	(9)	The average number of mid-level health care practitioners employed in the past 12 months.		
	divided by	The number of mid-level health care practitioner positions authorized in the past 12 months.		
	(10)	The average number of ancillary health care staff employed in the past 12 months.		
	divided by	The number of ancillary health care staff positions authorized in the past 12 months.		
7D		**The facility is administered efficiently and responsibly.**		
	(1)	Net amount of budget shortfalls or surplus at the end of the last fiscal year (budget less expenditures).	--	
	divided by	The budget for the past 12 months.	--	
	(2)	Number of material audit findings by an independent financial auditor at the conclusion of the last audit.	0	
		NONE		
	(3)	Number of grievances filed by inmates regarding their records or property in the past 12 months.	9	
	divided by	The average daily population in the past 12 months.	1420	.0063
	(4)	Number of inmate grievances (records/property) decided in favor of inmates in the past 12 months.	1	
	divided by	The total number of inmate grievances (records/property) in the past 12 months.	7	.1429
	(5)	Number of objectives achieved in the past 12 months.	1	
	divided by	The number of objectives for the past 12 months.	3	.3333
	(6)	Number of program changes made in the past 12 months.	4	
	divided by	The number of program changes recommended in the past 12 months.	7	.5714
	(7)	Number of problems identified by internal health care review that were corrected in the past 12 months.	6	

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	divided by	The number of problems identified by internal health care review in the past 12 months.	19	.3158
7E		**Staff are treated fairly.**		
	(1)	Number of grievances filed by staff in the past 12 months.	25	
	divided by	The number of full-time equivalent staff positions in the past 12 months.	(b)(7)(E)	
	(2)	Number of staff grievances decided in favor of staff in the past 12 months.	5	
	divided by	The total number of staff grievances in the past 12 months.	25	.2
	(3)	Total number of years of staff members' experience in the field as of the end of the last calendar year.	3175	
	divided by	The number of staff at the end of the last calendar year (e.g. average number of years' experience).	(b)(7)(E)	
	(4)	Number of staff termination or demotion hearings in which the facility decision was upheld in the past 12 months.		
	divided by	The number of staff termination or demotion hearings requested in the past 12 months.		
7F		**The facility is a responsible member of the community.**		
	(1)	Total number of hours of volunteer service delivered by members of the community in the past 12 months.	3695	
	divided by	The average daily population of inmates in the past 12 months.	1420	2.602
	(2)	Total number of individual community members who provided voluntary service in the past 12 months.	18	
	divided by	The average daily population of inmates in the past 12 months.	1420	.0126
	(3)	Total number of complaints filed by media regarding access to information in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1420	0
	(4)	Total number of positive statements made by media regarding the facility in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1420	0
	(5)	Total number of complaints from the community in the past 12 months.	1	

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	divided by	The average daily population of inmates in the past 12 months.	1420	.0007
	(6)	Total number of hours of community service work delivered by inmates in the past 12 months.	0	
	divided by	The average daily population of inmates in the past 12 months.	1420	0

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North

Otay Mesa Detention Center
7488 Calzada De Le Fuente
San Diego, CA 92154

(b)(7)(E)

South

AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

April 20, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Northwest Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Northwest Detention Center, Tacoma, WA during the period of April 18-20, 2017. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
QMC	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the April 2016 inspection.

Inspection Summary

The Northwest Detention Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified two (2) deficient components in the following two (2) standards:

Funds and Personal Property—1, which is a repeat deficiency
Recreation—1, which is a priority component

Facility Snapshot/Description

The Northwest Detention Center, a CDF, is owned and operated by the GEO Group, Inc. The facility is located in Tacoma, WA in a primarily industrial area approximately 25 miles south of the Sea-Tac International Airport, Seattle, WA. The facility houses all custody levels of male and female ICE detainees. The facility has a rated capacity of 1575. The population count on the first day of the inspection was 1295. The average length of stay for the previous twelve months was 79 days with an average daily population of 1435.

The Northwest Detention Center was constructed in 2004. In 2010, additional capacity was added to the facility. There are currently no plans for future construction or renovation. The administration building and the additional housing units constructed in 2010 are two levels; all other areas of the facility are single level. There are six general population housing units; four of the housing units each contain three housing pods and two of the housing units each contain four housing pods. Capacities of the housing units range from 205-278 beds. Both dormitory beds and cell housing is available at the facility. Dorm capacities range from 64-80 beds. Additionally, there are forty cells, each containing two beds, in the segregation management unit designated for males. All housing units are provided direct supervision around the clock. Detainees are afforded the opportunity for both indoor and outdoor recreation and were observed participating in both areas. Each housing unit has a large dayroom area equipped with tables, chairs, televisions, board games, ping pong tables, exercise equipment and microwaves. The entire facility is climate controlled. Telephones are available in the general population housing units at an optimal ratio of one telephone for every ten detainees. Detainees are issued color-coded uniforms and wristbands according to custody level.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. During the inspection sanitation at the facility was observed to be above average and noise levels were minimal. All facility and ICE staff encountered by the inspection team exhibited a professional demeanor. Interactions between staff and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC.

During the inspection, the Medical SME and QMC SME reviewed 123 medical files. Combined, all of the SMEs interviewed no less than fifty detainees which included detainees housed in the general population and in the segregation management units. Some interviews were confidential and included de-

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tainees who had limited English proficiency. Detainees' statements indicated general satisfaction with living conditions and with access to the law library, command staff, ICE personnel, telephones, medical care and translation services when needed.

One detainee stated that he was aware of a problem with foot fungus at the facility due to unsanitary shower conditions. The Security SME and the Medical SME followed-up on this complaint. The showers were observed to be very clean and sanitary and the medical department had no knowledge or record of any issues regarding foot fungus. Another detainee complained of lack of diversity in menu offerings. However, the safety SME reviewed the menu and observed meals during the inspection and found that the menu offerings meet the requirements of the standard. Additionally, the menu has been certified by a registered dietitian as exceeding minimum daily nutritional requirements.

Areas of Concern/Significant Observations

The inspection team identified one (1) deficient priority component:

Recreation
Component #5—All facilities shall have an individual responsible for the development and oversight of the recreation program. Every facility with a rated capacity of 350 or more detainees shall employ a full-time recreation specialist with special training in implementing and overseeing a recreation program, who assesses the needs and interests of the detainees.

Finding: The facility has a rated capacity of 1575. The total facility population on the first day of the inspection was 1295. The average daily population for the previous twelve months was 1435. The full-time recreation specialist position was eliminated since the previous annual inspection. The duties of the full-time recreation specialist have been assigned to the law library supervisor as collateral duties.

Recommendation: (b)(5)

(b)(5)

Recommended Rating and Justification

(b)(5)

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

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- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility (GEO) Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector April 20, 2017

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

April 19, 2018

TO: (b)(6); (b)(7)(C)
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Northwest Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Northwest Detention Center, Tacoma, Washington during the period of April 17-19, 2018. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the April 2017 inspection.

Inspection Summary

The Northwest Detention Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified two (2) deficient components in the following two (2) standards:

Funds and Personal Property—1, which is a repeat deficiency
Recreation—1, which is a repeat priority component deficiency

Facility Snapshot/Description

The Northwest Detention Center (NWDC), a CDF, is owned and operated by the GEO Group, Inc. The facility is located in Tacoma, Washington in an industrial area approximately twenty-five miles south of Sea-Tac International Airport. The facility houses all custody levels of male and female detainees. The facility has a rated capacity of 1575. The population count on the first day of the inspection was 1389, which included 126 females and 1263 males. The facility reported an average length of stay for the previous twelve months as eighty-one days.

The Northwest Detention Center was constructed in 2004. In 2010, additional capacity was added to the facility. There are currently no plans for future construction or renovation. The administration building and the additional housing units constructed in 2010 are two levels; all other areas of the facility are single level. There are six general population housing units; four of the housing units contain three housing pods and two of the housing units contain four housing pods. Capacities of the housing units range from 205-278 beds. Both dormitory and cell housing is available at the facility. Dorm capacities range from 64-80 beds. Additionally, there are forty cells, each containing two beds, in the segregation management unit designated for males. Housing units are provided direct supervision around-the-clock. Detainees are afforded the opportunity for both indoor and outdoor recreation and were observed participating in both areas. Each housing unit has a large dayroom area equipped with tables, chairs, televisions, board games, ping pong tables, exercise equipment and microwaves. The entire facility is climate controlled.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The sanitation levels were observed to be above average. Noise levels were minimal. Facility and ICE staff exhibited professional demeanor. Interactions between staff and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Medical and mental health services are provided by ICE Health Service Corp.

No less than seventy-five detainees were interviewed. Detainee statements indicated overall satisfaction with living conditions, access to the law library, telephones, medical care and translation services. Without exception, detainees stated that “they feel safe” and that "officers are respectful".

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Several detainees mentioned that beans are served "all the time". The safety SME reviewed the menu and observed meals during the inspection and found that the menu offerings meet the requirements of the standard.

Areas of Concern/Significant Observations

The inspection team identified one (1) repeat deficient priority component:

Recreation
Component #5—All facilities shall have an individual responsible for the development and oversight of the recreation program. Every facility with a rated capacity of 350 or more detainees shall employ a full-time recreation specialist with special training in implementing and overseeing a recreation program, who assesses the needs and interests of the detainees.

Finding: The facility has a rated capacity of 1575. The total facility population on the first day of the inspection was 1389. The average daily population for the previous twelve months was 1383. The full-time recreation specialist position was eliminated from the staffing plan in December 2016. The duties of the full-time recreation specialist have been assigned to the law library coordinator as collateral duties.

Recommendation: (b)(5)

(b)(5)

Recommended Rating and Justification

(b)(5)

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility (GEO) Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	April 19, 2018
Printed Name of LCI		Date

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National Commission on Correctional Health Care

ACCREDITATION REPORT OF

THE HEALTH CARE SERVICES AT

PORT ISABEL SERVICE PROCESSING CENTER

Los Fresnos, TX

July 19, 2019

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

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Port Isabel Service Processing Center, TX
July 19, 2019

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s.

The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On May 15-17, 2019, NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2018 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 39 essential standards. One hundred percent (100%) of the applicable essential standards must be met for accreditation. 37 are applicable to this facility and 37 (100%) were found to be in full compliance. Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
None

Standard number and name partially compliant:
None

Standard number and name not applicable:
J-C-06 Inmate Workers
J-E-03 Transfer Screening

There are 20 important standards; 19 are applicable to this facility and 19 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
None

Standard number and name partially compliant:
None

Standard number and name not applicable:
J-C-08 Health Care Liaison

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Decision: On July 19, 2019, NCCHC's Accreditation and Standards Committee awarded the facility accreditation.

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I. Facility Profile

The facility's security classification is: Medium
The facility was built in: 2005
The facility's mission or purpose has not change in the last year or since their last survey.
The facility is located in the southwestern United States.
The facility's supervision style is: Direct supervision
The facility's structural layout is: Linear and dormitory-style housing
Since the last NCCHC survey, there have not been any major renovations/expansions/closures in the facility, and none were anticipated at the time of the survey.
Total Inmate Count on day of survey: 1086
Total number of adult males on day of the survey: 1079
Total number of adult females on day of the survey: 7
Average Daily Population (ADP) for last completed calendar year: 1054
The design-rated capacity for the facility is: 1200
There has not been a substantial increase or decrease in the inmate population.
Admissions to the facility arrive: Scheduled, but any time of day or night
The total number of admissions to the facility last year was: 26,869
The average daily intake to the facility last year was: 77
The total number of correctional staff assigned to this facility is: (b)(7)(E)
The usual shift coverage for correctional staff is: (b)(7)(E)
There has not been a recent change in health care contractor
Health services are provided by a contracted vendor.
They have provided health services since: 2018
There have not been any distinctive events that may affect the delivery of health care.
The facility has no satellites.

II. Survey Method

We toured the clinic area, inmate housing areas, infirmary and segregation. We reviewed 16 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the Captain, responsible physician, health services administrator (HSA), other health, mental health, and dental staff, intake officer, two COs, and eight inmates selected at random.

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III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

Standards in this section address the establishment of a health care system that ensures access to care, professional administration of all aspects of health care, and monitoring and quality improvement policies that effectively process health care issues from identification through resolution.

Standard Specific Findings

J-A-01 Access to Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority identifies and eliminates any unreasonable barriers, intentional and unintentional, to inmates receiving health care.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-A-02 Responsible Health Authority (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The RHA arranges for all levels of health care and ensures quality, accessible, and timely health services for inmates.	X		
2. The RHA's responsibilities are documented in a written agreement, contract, or job description.	X		
3. The RHA must be on-site at least weekly.	X		
4. Final clinical judgments rest with a single, designated, licensed *responsible physician*.	X		
5. Where there is a separate organizational structure for mental health services, there is a *designated mental health clinician*.	NA		
6. Where there is a separate organizational structure for dental services, there is a *designated dental clinician*.	NA		
7. The responsible physician (and designated mental health clinician and dental clinician, if applicable) is available to the facility frequently enough to fulfill the position's clinical and administrative responsibilities.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
The mental health and dental operations are under the same authority as medical services.
The following corrective action is required:
None

J-A-03 Medical Autonomy (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Clinical decisions are determined by qualified health care professionals and implemented in an effective and safe manner.	X		
2. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized.	X		
3. *Custody staff* support the implementation of clinical decisions.	X		
4. *Health staff* recognize and follow security regulations.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-A-04 Administrative Meetings and Reports (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Administrative meetings are attended by the facility administrator and the responsible health authority (RHA) or their designees, and other members of the medical, dental, and mental health and correctional staffs as appropriate.	X		
2. Administrative meetings are held at least quarterly. Minutes or summaries are made and retained for reference, and copies available and reviewed by all appropriate personnel.	X		
3. Health staff meetings occur at least monthly to address pertinent health care issues. Minutes or summaries are made and retained for reference, and copies are available and reviewed by all health staff.	X		
4. Statistical reports of health services are made at least monthly. They are provided to the facility administrator and others as appropriate and are used to monitor trends in the delivery of health care.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

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J-A-05 Policies and Procedures (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Policies and procedures address each applicable standard in the *Standards for Health Services in Jails*.	X		
2. Health care policies and procedures are site specific.	X		
3. Health care policies and procedures are reviewed at least annually by the RHA and responsible physician.	X		
4. Documentation of this review includes signatures of the RHA and responsible physician and the date of the review.	X		
5. Health staff review policies and procedures any time they are revised or new policies are introduced.	X		
6. Other policies, such as those for custody, kitchen, industries, and health care vendor or other contractors, do not conflict with health care policies.	X		
7. The manual or compilation is accessible to health staff.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-A-06 Continuous Quality Improvement Program (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority establishes a continuous quality improvement program that includes a *quality improvement committee* with representatives from the major program areas. The committee meets as required but no less than quarterly. The committee:	X		
a. Identifies aspects of health care to be monitored and establishes *thresholds*	X		
b. Designs quality improvement monitoring activities	X		
c. Analyzes the results for factors that may have contributed to below threshold performance	X		
d. Designs and implements improvement strategies to correct the identified health care concern	X		

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e. Monitors the performance after implementation of the improvement strategies	X		
2. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel.	X		
3. *Health record reviews* are done under the guidance of the responsible physician or designee to ensure that appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health, and nursing.	X		
4. Beyond chart reviews, the responsible physician is involved in the CQI process.	X		
5. When the committee identifies a site-specific health care concern from its monitoring, a *process* and/or *outcome quality improvement study* is initiated and documented.	X		
6. At least one process and/or outcome quality improvement study is completed per year.	X		
7. The committee documents a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
CQI studies are well documented and consist of the required elements.			
The following corrective action is required:			
None			

J-A-07 Privacy of Care (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Discussions of protected patient health information and *clinical encounters* are conducted in private.	X		
2. Privacy (e.g., privacy screen, curtain, private area) should be afforded during physical exams, with special considerations for pelvic, rectal, breast, or other genital exams.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

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J-A-08 Health Records (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The method of recording entries in the health record and the *health record contents* and format are approved by the responsible health authority (RHA) or designee.	X		
2. If electronic health records are used, procedures address integration of health information in electronic and paper forms.	X		
3. Where mental health or dental records are separate from medical records:	NA		
a. A process ensures that pertinent information is shared			
b. At a minimum, a listing of current problems, allergies, and medications is common to all medical, dental, and mental health records of an inmate			
4. Evidence exists that the health record is available to health staff and health encounters are documented.	X		
5. Criminal justice information that is pertinent to clinical decisions is available to qualified health care professionals.	X		
6. Health records stored in the facility are maintained under secure conditions separate from correctional records.	X		
7. Access to health records and health information is controlled by the RHA.	X		
8. Evidence exists that health staff receive instruction in maintaining confidentiality.	X		
9. If records are transported by nonhealth staff, the records are sealed.	X		
10. When an inmate is transferred to another correctional facility:	X		
a. A copy of the current health record or a *comprehensive health summary* accompanies the inmate	X		
b. The transfer and sharing of health records complies with state and federal law	X		
11. There is a system for the reactivation of records when requested by health staff.	X		
12. The jurisdiction's legal requirements regarding records retention and release are followed.	X		
13. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
Mental health and dental operations fall under the same authority as medical services, and are all documented in the same charts.
The following corrective action is required:
None

J-A-09 Procedure in the Event of an Inmate Death (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A *clinical mortality review* is conducted within 30 days.	X		
2. An *administrative review* is conducted in conjunction with custody staff.	X		
3. A *psychological autopsy* is performed on all deaths by suicide within 30 days.	X		
4. Treating staff are informed of pertinent findings of all reviews.	X		
5. A log is maintained that includes:	X		
a. Patient name or identification number	X		
b. Age at time of death	X		
c. Date of death	X		
d. Date of clinical mortality review	X		
e. Date of administrative review	X		
f. Cause of death (e.g., hanging, respiratory failure)	X		
g. Manner of death (e.g., natural, suicide, homicide, accident)	X		
h. Date pertinent findings of review(s) shared with staff	X		
i. Date of psychological autopsy, if applicable	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-A-10 Grievance Process for Health Care Complaints (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A grievance process is in place.	X		
2. The grievance policy includes:	X		

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a. A time frame for response	X		
b. The process for appeal	X		
3. Responses to inmate grievances are:	X		
a. Timely	X		
b. Based on principles of adequate medical care	X		
c. Include documentation of response	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

B. HEALTH PROMOTION, SAFETY, AND DISEASE PREVENTION

Standards in this section address the need to optimize education, safety, and preventive care. Policies and procedures related to these standards require involvement by all facility staff.

Standard Specific Findings

J-B-01 Health Lifestyle Promotion (I)			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Health staff document that patients receive individual *health education* and instruction in *self-care* for their health conditions.	X		
2. General health education (e.g., pamphlets, news articles, video, classes) is accessible to all inmates.	X		
3. The facility provides a *nutritionally adequate* diet to the general population.	X		
4. A *registered dietitian nutritionist* (RDN), or other licensed qualified nutrition professional, as authorized by state scope of practice laws, documents a review of the regular diet for nutritional adequacy at least annually.	X		
5. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.	X		
6. Health staff promote and provide education on exercise and physical activity options in the facility.	X		
7. Smoking is prohibited indoors. If the facility allows smoking outside, specific areas are designated.	X		

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8. Information on the health hazards of tobacco is available to inmates.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-B-02 Infectious Disease Prevention and Control (E)			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility has a written *exposure control plan* that is approved by the responsible physician. The plan is reviewed and updated annually.	X		
2. The responsible health authority ensures that:	X		
a. Medical, dental, and laboratory equipment and instruments are appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations	X		
b. Sharps and biohazardous wastes are disposed of properly	X		
c. Surveillance to detect inmates with infectious and communicable disease is effective	X		
d. Inmates with contagious diseases are identified and, if indicated, *medically isolated* in a timely fashion	X		
e. Infected patients receive medically indicated care	X		
3. *Standard precautions* are always used by health staff to minimize the risk of exposure to blood and body fluids.	X		
4. Inmate workers, if used, are trained in appropriate methods for handling and disposing of biohazardous materials and spills.	X		
5. Patients requiring respiratory isolation are housed in a functional negative pressure room.	X		
6. Inmates who are released with communicable or infectious diseases have documented community referrals, as medically indicated.	X		
7. The facility completes and files all reports as required by local, state, and federal laws and regulations.	X		
8. Effective *ectoparasite* control procedures are used to treat infected inmates and to disinfect bedding and clothing.	X		

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a. Inmates, bedding, and clothing infected with ectoparasites are disinfected.	X		
b. Prescribed treatment considers all conditions (such as pregnancy, open sores, or rashes) and is ordered only by *providers*.	X		
c. If the facility routinely delouses inmates, only over-the-counter medications, such as those containing pyrethrin's, are used.	X		
9. An environmental inspection of health services areas is conducted monthly to verify that:	X		
a. Equipment is inspected and maintained	X		
b. The unit is clean and sanitary	X		
c. Measures are taken to ensure the unit is occupationally and environmentally safe	X		
10. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-B-03 Clinical Preventive Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible physician determines the medical necessity and/or timing of screenings and other preventive services (e.g., mammograms, colorectal screening, prostate screening, Pap smears).	X		
2. The responsible physician determines the frequency and content of periodic health assessments.	X		
3. The dentist determines the frequency and content of periodic dental evaluations.	X		
4. The responsible physician determines the medical necessity and/or timing of screening for communicable diseases (e.g., HIV, syphilis, gonorrhea, chlamydia), to include laboratory confirmation, treatment, and follow-up as clinically indicated.	X		
5. Immunizations are administered to patients as clinically indicated.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

J-B-04 Medical Surveillance of Inmate Workers (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. There is an institutional committee or equivalent body that identifies and oversees inmate occupational-associated risks through a *medical surveillance* program	X		
2. An initial *medical screening* of an inmate for contraindications to a work program, based on job risk factors and patient condition, is conducted prior to enrollment in the program.	NA		
3. Ongoing medical screening of inmates in work programs is conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs.	NA		
4. The responsible physician reviews and approves the health aspects of the medical surveillance program.	X		
5. Inmate illness or injury potentially related to occupational exposure or with occupational implications is identified and the information provided to the quality improvement committee for review.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
There is no work program at the facility due to the very transient nature of the inmate population. Food service and maintenance is conducted by civilian contractors and facility staff. Inmates are only used for minor clean up tasks, when needed.			
The following corrective action is required:			
None			

J-B-05 Suicide Prevention and Intervention (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority and facility administrator approve the facility's suicide prevention program.	X		
2. A suicide prevention program includes the following:	X		
a. Facility staff identify suicidal inmates and immediately initiate precautions.	X		
b. Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.	X		

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c. *Acutely suicidal* inmates are monitored by facility staff via constant observation.	X		
d. *Nonacutely suicidal* inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.	X		
3. The use of other inmates in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision.	X		
4. Treatment plans addressing suicidal ideation and its reoccurrence are developed.	X		
5. Patient follow-up occurs as clinically indicated.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-B-06 Contraception (I). ☐ **NOT APPLICABLE**			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Emergency contraception is available to women at intake.	X		
2. For planned releases to the community, arrangements are made to initiate contraception for women, upon request.	X		
3. Information about contraceptive methods and community resources is available.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-B-07 Communication on Patients' Health Needs (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Correctional staff are advised of inmates' special health needs that may affect:	X		
a. Housing	X		
b. Work assignments	X		
c. Program assignments or selection	X		

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d. Disciplinary measures		X		
e. Transport to and from outside appointments		X		
f. Admissions to and transfers from facilities		X		
g. Clothing or appearance		X		
h. Activities of daily living		X		
2. Communication of health needs is documented.		X		
3. All aspects of the standard are addressed by written policy and defined procedures.		X		
Compliance concern(s) or positive findings:				
None				
The following corrective action is required:				
None				

J-B-08 Patient Safety (I).				
		The compliance indicator is:		
		Fully Met	**Partially Met**	**Not Met**
1. Facility staff implement *patient safety systems* to prevent *adverse* and *near-miss* clinical events.		X		
2. The responsible health authority (RHA) implements a reporting system for health staff to voluntarily report, in a nonpunitive environment, adverse and near-miss events that affect patient safety.		X		
3. All aspects of the standard are addressed by written policy and defined procedures.		X		
Compliance concern(s) or positive findings:				
None				
The following corrective action is required:				
None				

J-B-09 Staff Safety (I).				
		The compliance indicator is:		
		Fully Met	**Partially Met**	**Not Met**
1. Methods of communication (e.g., radio, panic button, voice proximity) between health staff and custody staff are available.		X		
2. When a safety concern arises, custody staff are requested and readily available to health staff.		X		
3. On each shift where health staff are present, inventories are maintained on items subject to abuse (e.g., needles, scissors, other sharp instruments) and discrepancies are immediately reported to the custody staff.		X		

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4. As in the community, health staff identify and use contemporary equipment during the course of their duties (e.g., personal protective equipment, needle safety devices such as self-sheathing needles or needleless systems).	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

C. PERSONNEL AND TRAINING

Standards in this section ensure that appropriately trained personnel are in place to deliver health care to the inmate population and that qualified health care professionals are evaluated for continuing competency.

Standard Specific Findings

J-C-01 Credentials (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All qualified health care professionals have credentials and provide services consistent with the licensure, certification, and registration requirements of the jurisdiction.	X		
2. The responsible health authority (RHA) ensures that new hires undergo a credential verification process that confirms current licensure, certification, or registration.	X		
3. The credential verification process includes inquiry regarding sanctions or disciplinary actions of state boards and, for *prescribers*, the National Practitioner Data Bank (NPDB).	X		
4. Qualified health care professionals do not perform tasks beyond those permitted by their credentials.	X		
5. The RHA maintains verification of current credentials for all qualified health care professionals at a readily accessible location.	X		
6. A license that limits practice to only correctional health care is not in compliance with this standard.	X		
7. Specialists providing on-site or telehealth care services have appropriate licenses and certifications on file.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

J-C-02 Clinical Performance Enhancement (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Clinical performance enhancement reviews are conducted, at a minimum, on all full-time, part-time, or per diem:	X		
a. Providers	X		
b. RNs	X		
c. LPNs	X		
d. Psychologists	X		
e. Licensed clinical social workers	X		
f. Dentists	X		
2. The clinical performance enhancement review is conducted annually.	X		
3. Clinical performance enhancement reviews are kept confidential and incorporate at least the following elements:	X		
a. The name and credentials of the individual being reviewed	X		
b. The date of the review	X		
c. The name and credentials of the reviewer	X		
d. A summary of the findings and corrective action, if any	X		
e. Confirmation that the review was shared with the individual being reviewed	X		
4. A log or other written record listing the names of the individuals reviewed and the dates of their most recent reviews is available.	X		
5. The responsible health authority (RHA) implements an *independent review* when there is concern about any individual's competence.	X		
6. The RHA implements procedures to improve an individual's competence when such action is necessary.	X		
7. All aspects of the standard are addressed by written policy and defined procedures.	X		

Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

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J-C-03 Professional Development (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All qualified health care professionals obtain at least 12 hours of continuing education per year or have proof of a valid license in states where continuing education is required for licensure.	X		
2. The responsible health authority (RHA) documents compliance with continuing education requirements.	X		
3. The RHA maintains a list of the state's continuing education requirements for each category of licensure of all qualified health care professionals.	X		
4. All qualified health care professionals who have patient contact are current in cardiopulmonary resuscitation technique.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-C-04 Health Training for Correctional Officers (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A training program is established and approved by the responsible health authority in cooperation with the facility administrator.	X		
2. An outline of the training, including course content and length, is kept on file.	X		
3. Correctional officers who work with inmates receive health-related training at least every 2 years. This training includes, at a minimum:	X		
a. Administration of first aid	X		
b. Cardiopulmonary resuscitation including the use of an automated external defibrillator	X		
c. Acute manifestations of certain chronic illnesses (e.g., asthma, seizures, diabetes)	X		
d. Intoxication and withdrawal	X		
e. Adverse reactions to medications	X		
f. Signs and symptoms of mental illness	X		
g. Dental emergencies	X		
h. Procedures for suicide prevention	X		

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i. Procedures for appropriate referral of inmates with medical, dental, and mental health complaints to health staff	X		
j. Precautions and procedures with respect to infectious and communicable diseases	X		
k. Maintaining patient confidentiality	X		
4. A certificate or other evidence of attendance is kept on-site for each employee.	X		
5. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health-related training.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
The training program is robust, and documented well. We had access to all lesson plans, power point presentations, attendance records, and test results.			
The following corrective action is required:			
None			

J-C-05 Medication Administration Training (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Correctional or health staff who administer or deliver prescription medication to inmates must be permitted by state law to do so.	X		
2. Staff who administer or deliver prescription medications are trained in matters of:	X		
a. Security	X		
b. Accountability X	X		
c. Common side effects	X		
d. Documentation of administration of medicines	X		
3. The training is approved by the responsible physician or designee and facility administrator or designee.	X		
4. Documentation of completed training and testing is kept on file for staff who administer or deliver medications.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

J-C-06 Inmate Workers (E). X NOT APPLICABLE	The compliance indicator is:		
	Fully Met	Partially Met	Not Met
1. Inmates do not make treatment decisions or provide patient care.	X		
2. Inmates are not substitutes for health staff, but may be involved in appropriate peer health-related programs or *reentry health care training programs*.	X		
3. Other than those in a reentry health care training program, inmates are not permitted to:			
a. Distribute or collect sick-call slips	X		
b. Schedule appointments	X		
c. Transport or view health records	X		
d. Handle or administer medications	X		
e. Handle surgical instruments and sharps	X		
4. Inmates in peer-health related programs are permitted to:			
a. Assist patients in *activities of daily living* (except for infirmary-level care patients)	X		
b. Participate in a buddy system for nonacutely suicidal inmates after documented training	X		
c. Participate in hospice programs after documented training (see F-07 Care for the Terminally Ill)	X		
5. Patients have the right to refuse care delivered by inmates who are in a reentry health care training program (e.g., dental assistant, nursing assistant).	N/A		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
Inmates are not used for any of the services addressed in this standard			
The following corrective action is required:			
None			

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J-C-07 Staffing (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The RHA approves the staffing plan.	X		
2. Prescriber and nursing time must be sufficient to fulfill clinical responsibilities.	X		
3. Responsible physician time must be sufficient to fulfill administrative responsibilities.	X		
4. A documented plan is in place for custody staff to follow when a health situation arises and health staff are not present.	X		
5. The adequacy and effectiveness of the staffing plan are assessed by the facility's ability to meet the health needs of the inmate population.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

Staffing Plan

Number of On-Site Health Staff (Full-Time Equivalents) *Someone working a regular 40 hour week is considered 1.0 FTE. To calculate FTEs, take the total number of hours by employee category and divide by 40 (or the jurisdiction's equivalent of a full-time workweek). For example, someone working 16 hours would be a .40 FTE (16/40 = .40); 5 part-time LPNs working a total of 60 hours would be 1/5 FTE (60/40 = 1.5).*

Employee Category	Main Unit	Satellites		Vacant
		1	2	
Administrator (HSA)	(b)(7)(E)			
Administrative Assistant				
Medical Assistant				
Discharge Planner				
Physician				
Physician Assistant				
Nurse Practitioner				
Registered Nurse				
Licensed Practical Nurse				
Psychiatrist				
Psychologist				
Mental Health Worker				
Dentist				
Dental Assistant/Hygienist				
Pharmacist				
Health Records Personnel				
Lab/X-ray Technician				
EMT or MA				
Assistant HSA				
Infirmary control				
Program manager				

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J-C-08 Health Care Liaison (I).	X NOT APPLICABLE		
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A designated, trained *health care liaison* coordinates health services delivery in the facility and satellite(s) on days when no qualified health care professionals are on-site for a continuous 24-hour period.			
2. The health care liaison is instructed in the role and responsibilities by the responsible physician or designee.			
3. The health care liaison should have a plan that includes contact information for the on-call health staff, ambulance, and other emergency community contacts.			
4. The health care liaison receives instruction in reviewing patient information.			
5. The health care liaison maintains confidentiality of patient information.			
6. Duties assigned to the health care liaison post are appropriately carried out.			
7. All aspects of the standard are addressed by written policy and defined procedures.			
Compliance concern(s) or positive findings:			
Health staff are present 24 hours a day.			
The following corrective action is required:			
None			

J-C-09 Orientation for Health Staff (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The orientation program is approved by the responsible health authority and the facility administrator.	X		
2. The orientation lesson plan is reviewed annually or more frequently, as needed.	X		
3. All health staff receive a *basic orientation* on or before the first day of on-site service.	X		
4. Within 90 days of employment, all health staff complete an *in-depth orientation*.	X		
5. Completion of the orientation program is documented and kept on file.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

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D. ANCILLARY HEALTH CARE SERVICES

Standards in this section address the establishment and maintenance of all necessary procedures for the provision of ancillary health care services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility complies with all applicable state and federal regulations regarding prescribing, *dispensing*, *administering*, *procuring,* and *disposing* of pharmaceuticals.	X		
2. The facility maintains procedures for the timely procurement, dispensing, *distribution*, *accounting*, and disposal of pharmaceuticals.	X		
3. The facility maintains records as necessary to ensure adequate control and accountability for all medications, except those that may be purchased over the counter.	X		
4. The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency *(DEA)-controlled substances*.	X		
5. Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications, except in a designated area for disposal.	X		
6. A staff or consulting pharmacist documents inspections and consultations of all sites, including satellites, at least quarterly.	X		
7. All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.	X		
8. Antiseptics, other medications for external use, and disinfectants are stored separately from internal and injectable medications. Medications requiring special storage (e.g., refrigeration) for stability are so stored.	X		
9. An adequate and proper supply of antidotes and other emergency medications (e.g., naloxone, epinephrine) and related information are readily available to the staff.	X		
10. The poison control telephone number is posted in areas where overdoses or toxicologic emergencies are likely.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
This facility is to be commended for their pharmacy operations. It is staffed by (b)(7)(E) who hold high rank within the organization, and (b)(7)(E) are the only people with access to the pharmacy. Great detail is paid to security of medication practices, as well as procurement, administration, and dispensing practices, accountability and staff education in medication management .
The following corrective action is required:
None

J-D-02 Medication Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Medications are administered or delivered to the patient in a timely and safe manner.	X		
2. Prescription medications are given only by order of a physician, dentist, or other legally authorized individual.	X		
3. A policy identifies the expected time frames from ordering to administration or delivery to the patient and a backup plan if the time frames cannot be met.	X		
4. The responsible physician determines prescribing practices in the facility.	X		
5. If the facility maintains a *formulary*, there should be a documented process for obtaining nonformulary medications in a timely manner.	X		
6. Medications are prescribed only when clinically indicated.	X		
7. Medications are kept under the control of appropriate staff members, except for *self-medication programs* approved by the facility administrator and responsible physician.	X		
8. Inmates are permitted to carry medications necessary for the emergency management of a condition when ordered by a prescriber.	X		
9. Inmates entering the facility on verifiable prescription medication continue to receive the medication in a timely fashion, or justification for an alternate treatment plan is documented.	X		
10. The ordering prescriber is notified of the impending expiration of an order so that the prescriber can determine whether the drug administration is to be continued or altered.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

J-D-03 Clinic Space, Equipment, and Supplies (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Examination and treatment rooms for medical, dental, and mental health care are available and equipped to meet the needs of the patient population.	X		
2. Pharmaceuticals, medical supplies, and mobile emergency equipment are available and checked in accordance with policy.	X		
3. There is adequate office space with administrative files, secure storage of health records, and writing desks.	X		
4. When laboratory, radiological, or other ancillary services are provided on-site, the designated area is adequate to hold equipment and records.	X		
5. When patients are placed in a waiting area for more than a brief period, the waiting area has seats and access to drinking water and toilets.	X		
6. The facility has, at a minimum, the following equipment, supplies, and materials for the examination and treatment of patients:	X		
a. Hand-washing facilities or alternate means of hand sanitization	X		
b. Examination table	X		
c. A light capable of providing direct illumination	X		
d. Scale	X		
e. Thermometers	X		
f. Blood pressure monitoring equipment	X		
g. Stethoscope	X		
h. Ophthalmoscope	X		
i. Otoscope	X		
j. Transportation equipment (e.g., wheelchair, stretcher)	X		
k. Trash containers for biohazardous materials and sharps	X		
l. Sterilizer for non-disposable medical or dental equipment	X		
m. Appropriate space, equipment, and supplies for pelvic examinations if the facility houses females.	X		

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n. Oxygen	X		
o. Automated external defibrillator	X		
p. Pulse oximeter	X		
q. Personal protective equipment (e.g., gloves, eye protection, gowns, masks)	X		
7. Basic equipment required for on-site dental examinations includes, at a minimum:	X		
a. Hand-washing facilities or alternate means of hand sanitization	X		
b. Dental examination chair	X		
c. Examination light	X		
d. Instruments	X		
e. Trash containers for biohazardous materials and sharps	X		
f. A dentist's stool	X		
g. Personal protective equipment	X		
8. The presence of a dental operatory requires the addition of at least:	X		
a. An X-ray unit with developing capability	X		
b. Blood pressure monitoring equipment	X		
c. Oxygen	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
The lab equipment and dental operatory include advanced technological equipment, including a state of the art autoclave, three dental chairs and very high-tech X-ray capabilities.			
The following corrective action is required:			
None			

J-D-04 On-Site Diagnostic Services (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority maintains documentation that on-site diagnostic services (e.g., laboratory, radiology) are certified or licensed to provide that service.	X		
2. There is a procedure manual for each on-site diagnostic service, including protocols for the calibration of testing devices to ensure accuracy.	X		

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3. Facilities have, at a minimum, multiple-test dipstick urinalysis, finger-stick blood glucose tests, peak flow meters (handheld or other), stool blood-testing material, and in facilities housing women, pregnancy test kits.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-D-05 Medical Diets (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Medical diets are provided per prescriber order and documented in the health record.	X		
2. Orders for medical diets are communicated in writing to dietary staff and include the type of diet, the duration for which it is to be provided, and special instructions, if any.	X		
3. A registered dietitian nutritionist (RDN) or other licensed qualified nutrition professionals, as authorized by state scope of practice laws, documents a review of all medical diets for nutritional adequacy at least annually.	X		
4. The facility has a procedure in place to notify the RDN whenever the medical diet menu is changed.	X		
5. Written documentation of menu reviews includes the date, signature, and title of the dietitian.	X		
6. Workers who prepare medical diets are supervised in diet preparation.	X		
7. When inmates refuse prescribed diets, follow-up nutritional counseling is provided.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
All food service workers are civilian contractors. Inmates do not prepare foods or assist in preparation of food.			
The following corrective action is required:			
None			

J-D-06 Patient Escort (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients are transported safely and in a timely manner for medical, dental, and mental health clinic appointments both inside and outside the facility.	X		

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2. Patient confidentiality is maintained during transport.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-D-07 Emergency Services and Response Plan (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility provides 24-hour emergency medical, dental, and mental health services.	X		
2. Facility staff provide emergency services until qualified health care professionals arrive.	X		
3. The health aspects of the documented emergency response plan are approved by the responsible health authority and facility administrator, and include, at a minimum:	X		
a. Responsibilities of health staff	X		
b. Procedures for triage for multiple casualties	X		
c. Predetermination of the site for care	X		
d. Emergency transport of the patient(s) from the facility	X		
e. Use of an emergency vehicle	X		
f. Telephone numbers and procedures for calling health staff and the community emergency response system (e.g., hospitals, ambulances)	X		
g. Use of one or more designated hospital emergency departments or other appropriate facilities	X		
h. Emergency on-call physician, dental, and mental health services when the emergency health care facility is not nearby	X		
i. Security procedures for the immediate transfer of patients for emergency care	X		
j. Procedures for evacuating patients in a mass disaster	X		
k. Alternate backups for each of the plan's elements	X		
l. Time frames for response	X		
m. Notification to the person legally responsible for the facility	X		

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4. *Mass disaster drills* are conducted so that each shift has participated over a 3-year period, including satellites.	X		
5. A health emergency *man-down drill* is practiced once a year on each shift where health staff are regularly assigned, including satellites.	X		
6. The mass disaster and man-down drills are *critiqued*, the results are shared with all health staff, and recommendations for health staff are acted upon.	X		
7. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-D-08 Hospital and Specialty Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Evidence demonstrates that there is appropriate and timely access to hospital and specialist care when necessary.	X		
2. When patients are referred for outside care, written or verbal information about the patient and the specific problem to be addressed must be communicated to the outside entity.	X		
3. The health record contains results and recommendations from off-site visits, or attempts by health staff to obtain these results.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

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E. PATIENT CARE AND TREATMENT

Standards in this section ensure the delivery of health care from arrival through discharge for health care issues. All care is timely and appropriate and continues until resolution of the problem or until discharge.

Standard Specific Findings

J-E-01 Information on Health Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A sign explaining how to access health services is posted in the intake/processing area.	X		
2. Within 24 hours of their arrival, inmates are provided with written, electronic, or video information about:	X		
a. How to access emergency and routine medical, dental, and mental health services	X		
b. The fee-for-service program, if one exists	X		
c. The grievance process for health-related complaints	X		
3. Procedures ensure that inmates who have difficulty communicating (e.g., foreign speaking, developmentally disabled, illiterate, mentally ill, deaf) understand how to access health services.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-E-02 Receiving Screening (E) ☐ NOT APPLICABLE			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Reception personnel ensure that persons who are unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal, or otherwise urgently in need of medical attention are referred immediately for care and *medical clearance* into the facility.	X		
a. If they are referred to a community hospital and then returned, admission to the facility is predicated on written medical clearance from the hospital.	X		
2. A *receiving screening* takes place as soon as possible upon acceptance into custody.	X		

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3. The receiving screening form is approved by the responsible health authority and inquires as to the inmate's:	X		
a. Current and past illnesses, health conditions, or special health requirements (e.g., hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine dietary)	X		
b. Past infectious disease	X		
c. Recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats)	X		
d. Past or current mental illness, including hospitalizations	X		
e. History of or current suicidal ideation	X		
f. Dental problems (decay, gum disease, abscess)	X		
g. Allergies	X		
h. Dietary needs	X		
i. Prescription medications (including type, amount, and time of last use)	X		
j. Legal and illegal drug use (including type, amount, and time of last use)	X		
k. Current or prior withdrawal symptoms	X		
l. Possible, current, or recent pregnancy	X		
m. Other health problems as designated by the responsible physician	X		
4. The form also records reception personnel's observations of the inmate's:	X		
a. Appearance (e.g., sweating, tremors, anxious, disheveled)	X		
b. Behavior (e.g., disorderly, appropriate, insensible)	X		
c. State of consciousness (e.g., alert, responsive, lethargic)	X		
d. Ease of movement (e.g., body deformities, gait)	X		
e. Breathing (e.g., persistent cough, hyperventilation)	X		
f. Skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse)	X		
5. The disposition of the inmate (e.g., immediate referral to an appropriate health care service, placement in the general population) is appropriate to the findings of the receiving screening and is indicated on the receiving screening form.	X		

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6. Receiving screening forms are dated and timed immediately on completion and include the name, signature and title of the person completing the form.	X		
7. All immediate health needs are identified through the screening and properly addressed by qualified health care professionals.	X		
8. Potentially infectious inmates are isolated from the general inmate population	X		
9. If a woman is pregnant, an opiate history is obtained.	X		
10. If a woman reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to fetus.	X		
11. When health-trained correctional personnel perform the receiving screening, they have documented training by the responsible physician or designee in early recognition of medical, dental, and mental health conditions requiring clinical attention.	X		
12. Health staff regularly monitor receiving screenings to determine the safety and effectiveness of this process.	X		
13. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-E-03 Transfer Screening (E).	**X NOT APPLICABLE**		
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Qualified health care professionals review each transferred inmate's health record or summary to ensure continuity of care and medications.			
2. When transferred from an intake facility, inmates who do not have initial medical, dental, or mental health assessments are to be evaluated at the receiving facility in a timely manner.			
3. Documentation in the health record demonstrates continuity of health care and medication administration.			
4. All aspects of the standard are addressed by written policy and defined procedures.			
Compliance concern(s) or positive findings:			
All inmates undergo a receiving screening			
The following corrective action is required:			
None			

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J-E-04 Initial Health Assessment (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
Compliance Indicators: Full Population Assessment (1-9) ☐ **NOT APPLICABLE**			
1. Receiving screening results are reviewed within 14 days.	X		
2. All inmates receive an initial health assessment as soon as possible, but no later than 14 calendar days after admission to the facility.	X		
3. If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation in the health record must confirm that the new receiving screening shows no change in health status.	X		
a. If the receiving screening shows a change in health status, the initial health assessment is repeated.	X		
4. The responsible physician determines the components of an initial health assessment.	X		
5. Initial health assessments include, at a minimum:	X		
a. A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from positive findings obtained during the receiving screening and subsequent encounters	X		
b. A qualified health care professional recording of vital signs (including height and weight)	X		
c. A *physical examination* (as indicated by the patient's gender, age, and risk factors) performed by a physician, physician assistant, nurse practitioner, or RN.	X		
d. A screening test for latent tuberculosis (e.g., PPD, chest X-ray, laboratory test), unless completed prior to the initial health assessment.	X		
6. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider.	X		
7. Specific problems are integrated into an initial problem list.	X		
8. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance Indicators: Individual Assessment When Clinically Indicated (10-16)	X	NOT APPLICABLE	
10. Inmates identified with *clinically significant findings* as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission. To qualify for this option, an institution:			
a. Has 24-hour, 7-day on-site health staff coverage			
b. Allows only licensed health care personnel to conduct a comprehensive receiving screening on all inmates			
c. Includes in its comprehensive receiving screening all elements of the receiving screening standard plus:			
i. Further inquiry into past history and symptoms of chronic diseases			
ii. Finger stick on individuals with diabetes			
iii. Vital signs (including pulse, respirations, blood pressure, and temperature)			
iv. Further inquiry into medication and dosages where possible			
v. A screening test for latent tuberculosis (e.g., PPD, chest X-ray, laboratory test.			
11. If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation must confirm that the new receiving screening shows no change in health status.			
a. If the comprehensive receiving screening shows a change in health status, the initial health assessment is repeated.			
12. The responsible physician determines the components of an initial health assessment.			
13. Individual health assessments include, at a minimum:			
a. A review of comprehensive receiving screening results			
b. A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from positive findings obtained during the receiving screening and subsequent encounters			
c. A qualified health care professional recording of vital signs (including height and weight)			
d. A physical examination (as indicated by the patient's gender, age, and risk factors) performed by a provider.			
e. Laboratory and/or diagnostic tests for disease, such as peak flow for asthma patients and blood work for diabetes patients.			
14. Specific problems are integrated into an initial problem list.			

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15. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.			
16. All aspects of the standard are addressed by written policy and defined procedures.			
Compliance concern(s) or positive findings:			
The facility only uses the full population screening			
The following corrective action is required:			
None			

J-E-05 Mental Health Screening and Evaluation (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Mental health screening is performed as soon as possible but no later than 14 calendar days after admission.	X		
2. Mental health screening may be conducted by *qualified mental health professionals* or qualified health care professionals who have received documented training.	X		
3. The initial mental health screening includes a structured interview with inquiries into:	X		
a. A history of:	X		
i. Psychiatric hospitalization and outpatient treatment	X		
ii. Substance use hospitalization	X		
iii. Withdrawal seizures	X		
iv. Detoxification and outpatient treatment	X		
v. Suicidal behavior	X		
vi. Violent behavior	X		
vii. Victimization	X		
viii. Special education placement	X		
ix. Cerebral trauma	X		
x. Sexual abuse	X		
xi. Sex offenses	X		
b. The current status of:	X		
i. Psychotropic medications	X		
ii. Suicidal ideation	X		
iii. Drug or alcohol use	X		

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iv. Drug or alcohol withdrawal or intoxication	X		
v. Orientation to person, place, and time	X		
c. Emotional response to incarceration	X		
d. A *screening for intellectual functioning* (i.e., mental retardation, developmental disability, learning disability)	X		
4. The patient's health record contains results of the initial screening.	X		
5. Inmates who screen positive for mental health problems are referred to *qualified mental health professionals* for further evaluation.	X		
6. Mental health evaluations of patients with positive screens should be completed within 30 days or sooner if clinically indicated.	X		
7. Patients who require acute mental health services beyond those available on-site are transferred to an appropriate facility.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-E-06 Oral Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. *Oral care* under the direction and supervision of a licensed dentist is provided to each inmate.	X		
2. Care is timely and includes immediate access for urgent conditions.	X		
3. *Oral screening* is performed as soon as possible but no later than 14 calendar days from admission.	X		
4. Oral screening may be done by the dentist or qualified health care professional who has received documented training approved or provided by the dentist.	X		
5. Instruction in oral hygiene and preventive oral education are given within 14 days of admission.	X		
6. An initial *oral examination* is performed by a dentist within 12 months of admission.	X		

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7. *Oral treatment*, not limited to extractions, is provided according to a treatment plan based on a system of established priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected.	X		
8. Radiographs are used in the development of the treatment plan.	X		
9. Consultation through referral to oral health care specialists is available as needed.	X		
10. Each inmate has access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the individual's needs.	X		
11. Extractions are performed in a manner consistent with community standards of care.	X		
12. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
Staffing includes (b)(7)(E) The dental area has three chairs and is very modern, with high-tech equipment.			
The following corrective action is required:			
None			

J-E-07 Nonemergency Health Care Requests and Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All inmates, regardless of housing assignment, are given the opportunity to submit oral or written *health care requests* at least *daily*.	X		
2. The health care requests are picked up daily by health staff.	X		
3. Health care requests are reviewed and prioritized daily by qualified health care professionals, or the health care liaison if applicable.	X		
4. A face-to-face encounter for a health care request is conducted by a qualified health care professional, or the health care liaison (if applicable), within 24 hours of receipt by health staff.	X		
5. Patients are evaluated in a *clinical setting* as indicated.	X		
6. All aspects of the health care request process, from review and prioritization to subsequent encounter, are documented, dated, and timed.	X		
7. The frequency and duration of response to health services requests is sufficient to meet the health needs of the inmate population.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
Sick call slips are picked up every morning and each inmate is seen that day. Many inmates are seen within an hour of submitting a health services request.
The following corrective action is required:
None

J-E-08 Nursing Assessment Protocols and Procedures (I). ☐ NOT APPLICABLE	The compliance indicator is:		
	Fully Met	Partially Met	Not Met
1. Nursing assessment protocols and nursing procedures:	X		
a. Are used by nursing personnel	X		
b. Are appropriate to the level of competency and preparation of the nurses who will carry them out	X		
c. Comply with the state practice act in the facility's jurisdiction	X		
2. Protocols and procedures are developed and reviewed annually by the nursing administrator and responsible physician based on the level of care provided in the facility.	X		
3. The protocols and procedures are accessible to all nursing staff.	X		
4. There is documentation of nurses' training in use of nursing assessment protocols and nursing procedures based on the level of care provided by the nurse. Documentation includes:	X		
a. Evidence that new nursing staff are trained and demonstrate knowledge and competency for the protocols and procedures that are applicable to their scope of practice	X		
b. Evidence of annual review of competency	X		
c. Evidence of retraining when protocols or procedures are introduced or revised	X		
5. Nursing assessment protocols for nonemergency health care requests include over-the-counter medications only.	X		
6. Approved assessment protocols pertaining to emergency life-threatening conditions (e.g., chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.	X		
7. Emergency administration of prescription medications requires a provider's order before or immediately after administration.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		

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Compliance concern(s) or positive findings:
None
The following corrective action is required:
None

J-E-09 Continuity, Coordination, and Quality of Care During Incarceration (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients receive medical, dental, and mental health services from admission to discharge per prescribers' recommendations, orders, and evidence-based practices.	X		
2. Prescriber orders are implemented in a timely manner.	X		
3. If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody is documented.	X		
4. Diagnostic tests are reviewed by the provider in a timely manner.	X		
5. Treatment plans are modified as clinically indicated by diagnostic tests and treatment results.	X		
6. Treatment plans, including test results, are shared with patients.	X		
7. For hospitalization, urgent care, emergency department, or specialty visits:	X		
a. Patients are seen by a qualified health care professional or health care liaison (if appropriate) upon return	X		
b. Recommendations are reviewed for appropriateness of use in the correctional environment	X		
c. A provider is contacted in a timely manner to ensure proper implementation of any orders and to arrange appropriate follow-up	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-E-10 Discharge Planning (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. For planned discharges, health staff arrange for a *reasonable supply* of current medications.	X		

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2. For patients with serious medical, dental, or mental health needs, arrangements or referrals are made for follow-up services with community prescribers, including exchange of clinically relevant information.	X		
3. All aspects of discharge planning are documented in the health record.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

F. SPECIAL NEEDS AND SERVICES

Standards in this section address patients with special health care needs and establish compliance requirements specific to each health care issue

Standard Specific Findings

J-F-01 Patients with Chronic Disease and Other Special Needs (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients with chronic diseases and other *special needs* are identified.	X		
2. The responsible physician establishes and annually approves clinical protocols.	X		
3. Clinical protocols are consistent with *national clinical practice guidelines*.	X		
4. Clinical protocols for the identification and management of chronic diseases or other special needs include, but are not limited to, the following:	X		
a. Asthma	X		
b. Diabetes	X		
c. HIV	X		
d. Hyperlipidemia	X		
e. Hypertension	X		
f. Mood Disorders	X		
g. Psychotic disorders	X		

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5. Individualized *treatment plans* are developed by a physician or other qualified provider at the time the condition is identified and updated when warranted.	X		
6. Documentation in the health record confirms that providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:	X		
a. Determining the frequency of follow-up for medical evaluation based on disease control	X		
b. Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome	X		
c. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication)	X		
d. Documenting patient education (e.g., diet, exercise, medication)	X		
e. Clinically justifying any deviation from the protocol	X		
7. Chronic illnesses and other special needs requiring a treatment plan are listed on the master problem list.	X		
8. Medical and dental orthoses, prostheses, and other *aids to reduce effects of impairment* are supplied in a timely manner when patient health would otherwise be adversely affected, as determined by the responsible physician or dentist.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-F-02 Infirmary-Level Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Policy defines the scope of medical, psychiatric, and nursing care available on-site to patients who need infirmary-level care.	X		
2. Patients who need infirmary-level care are always within sight or hearing of a facility staff member, and a qualified health care professional can respond in a timely manner.	X		

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3. The number of qualified health care professionals providing infirmary level care is based on the number of patients, the severity of their illnesses, and the level of care required for each.	X		
4. At least daily, a supervising RN ensures that care is being provided as ordered. Initiation and discontinuation of infirmary-level care is by provider order.	X		
5. The frequency of provider and nursing rounds for patients who need infirmary-level care is specified based on clinical acuity and the categories of care provided.	X		
6. Health records for patients who need infirmary-level care include:	X		
a. Initial clinical note that documents the reason for infirmary-level care and outlines the treatment and monitoring plan	X		
b. Complete documentation of the care and treatment given	X		
7. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
The infirmary is well-staff and equipped with modern equipment. It includes eight functional negative pressure rooms.			
The following corrective action is required:			
None			

J-F-03 Mental Health Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients' mental health needs are addressed on-site or by referral to appropriate alternative facilities.	X		
2. Outpatient services include, at a minimum:	X		
a. Identification and referral of inmates with mental health needs	X		
b. Crisis intervention services	X		
c. Psychotropic medication management, when indicated	X		
d. Individual counseling	X		
e. Group counseling and/or psychosocial/psychoeducational programs	X		
f. Treatment documentation and follow-up	X		
3. When commitment or transfer to an inpatient psychiatric setting is clinically indicated:	X		
a. Required procedures are followed	X		

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b. The transfer occurs in a timely manner	X		
c. The patient is safely housed and adequately monitored until the transfer occurs	X		
4. Outpatients receiving mental health services are seen as clinically indicated and as prescribed in their individual treatment plans.	X		
5. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-F-04 Medically Supervised Withdrawal and Treatment (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Protocols exist for managing inmates under the influence of or undergoing withdrawal from alcohol, sedatives, opioids, and/or other substances.	X		
2. Protocols for intoxication and withdrawal are approved by the responsible physician annually and are consistent with nationally accepted treatment guidelines.	X		
3. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using approved protocols as clinically indicated until symptoms have resolved.	X		
4. Individuals being monitored are housed in a safe location that allows for effective monitoring.	X		
5. If the findings from patient monitoring meet the national guidelines to begin prescription medications, *medically supervised withdrawal* is implemented.	X		
6. Medically supervised withdrawal is done under provider supervision.	X		
7. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a licensed acute care facility.	X		
8. The facility has a policy that addresses the management of inmates on medication-assisted treatment (MAT).	X		

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9. Inmates entering the facility on MAT have their medication continued, or a plan for medically supervised withdrawal is initiated.	X		
10. Disorders associated with alcohol and other drugs (e.g., HIV, liver disease) are recognized and treated.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
While all elements of this standard are covered by applicable policy, in practice, any inmate showing symptoms of detoxification is immediately transferred to the hospital. While awaiting transport, CIWA or COWS protocols apply.			
The following corrective action is required:			
None			

J-F-05 Counseling and Care of the Pregnant Inmate (E).	☐ **NOT APPLICABLE**		
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Counseling and assistance are provided and documented in accordance with the pregnant inmate's expressed desires regarding her pregnancy, whether she elects to keep the child, use adoptive services, or have an abortion.	X		
2. Prenatal care includes:	X		
a. Medical examinations by a provider qualified to provide prenatal care	X		
b. Prenatal laboratory and diagnostic tests in accordance with national guidelines	X		
c. Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions	X		
d. Counseling and administering recommended vaccines in accordance with national guidelines	X		
3. Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT) with methadone or buprenorphine.	X		
4. Emergency delivery kits are available in the facility.	X		
5. Custody restraints are not used during labor and delivery.	X		

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6. Custody restraints, if used, at other points of pregnancy and the postpartum period shall be limited to handcuffs in front of the body.	X		
7. *Postpartum care* is provided and documented.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-F-06 Response to Sexual Abuse (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility has guidelines or protocols regarding the detection, prevention, and reduction of sexual abuse.	X		
2. Health staff are trained in how to:	X		
a. Detect, assess, and respond to signs of sexual abuse and sexual harassment	X		
b. Preserve physical evidence of sexual abuse	X		
3. Emergency contraception is available to female victims of sexual assault.	X		
4. Recent sexual assault is either referred to a community facility for treatment and gathering of evidence, or if these procedures are performed in-house, the following guidelines are used:	X		
a. A history is taken and qualified health care professionals conduct an examination to document the extent of physical injury and to determine whether referral to another medical facility is indicated.	X		
b. Personnel trained in examination of sexual abuse victims will conduct the exam.	X		
c. Whenever possible, the examiner will not have a therapeutic relationship with individuals involved in the incident.	X		
d. With the victim's consent, the examination includes collection of evidence from the victim, using a kit approved by the local legal authority.	X		
5. In all cases, whether the victim is treated in-house or referred to an outside facility, the following activities occur:	X		

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a. Prophylactic treatment and follow-up care for sexually transmitted infections or other communicable diseases (e.g., HIV, hepatitis B) are offered to all victims, as appropriate.	X		
b. There is an evaluation by a qualified mental health professional for crisis intervention counseling and follow-up.	X		
c. A report is made to the correctional authorities to effect a separation of the victim from the abuser in their housing assignments.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-F-07 Care for the Terminally Ill (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A program to address the needs of terminally ill inmates includes *palliative care*.	X		
2. When the responsible physician determines that care in a community setting is medically preferable, a recommendation is made to the appropriate legal authority regarding the patient's transfer or *early release*.	X		
3. If there is an on-site palliative care program:	X		
a. Enrollment is a patient's informed choice	X		
b. Qualified health care professionals working in the program have received training in palliative care techniques	X		
c. Inmate workers or volunteers providing services in the program are properly trained and supervised	NA		
4. *Advance directives*, health care proxies, and "do not resuscitate" (DNR) orders are available when medically appropriate.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
No inmates are involved in this type of program.			
The following corrective action is required:			
None			

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G. MEDICAL – LEGAL ISSUES

The standards in this section ensure that health services comply with legal requirements.

Standard Specific Findings

J-G-01 Restraint and Seclusion (E).	*The compliance indicator is:*		
	Fully Met	**Partially Met**	**Not Met**
1. With regard to *clinically ordered restraint* and *seclusion*:			
a. Policies and procedures specify:	NA		
i. The types of restraints or conditions of seclusion that may be used	NA		
ii. When, where, how, and for how long restraints or seclusion may be used	NA		
iii. How proper peripheral circulation is maintained when restraints are used	NA		
iv. That proper nutrition, hydration, and toileting are provided	NA		
b. In each case, use is authorized by a physician or other qualified health care professional where permitted by law, after reaching the conclusion that no other less restrictive treatment is appropriate.	NA		
c. Unless otherwise specified by a physician or other qualified health care professional, health-trained personnel or health staff evaluate any patient placed in clinically ordered restraints or seclusion at an interval of no greater than every 15 minutes and document their findings.	NA		
d. The treatment plan provides for removing patients from restraints or seclusion as soon as possible.	NA		
e. The same types of restraints that would be appropriate for individuals treated in the community are used in the facility.	NA		
f. Patients are not restrained in a position that could jeopardize their health.	NA		
2. With regard to *custody-ordered restraints*:			
a. When restraints are used by custody staff for security reasons, a qualified health care professional is notified immediately in order to:	X		

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i. Review the health record for any contraindications or accommodations required, which, if present, are immediately communicated to appropriate custody staff	X		
ii. Initiate health monitoring, which continues at medically appropriate intervals as long as the inmate is restrained. If the inmate's health is at risk, this is immediately communicated to appropriate custody staff.	X		
iii. If health staff are not on duty when custody-ordered restraints are initiated, it is expected that health staff review the health record and initiate monitoring upon arrival	X		
b. If the restrained inmate has or develops a medical or mental health condition, the provider is notified immediately so that appropriate orders can be given.	X		
c. When health staff note use of restraints that may be jeopardizing an inmate's health, this is communicated to custody staff immediately.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
Clinical restraints are not used at this facility.			
The following corrective action is required:			
None			

J-G-02 Segregated Inmates (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Upon notification that an inmate has been placed in segregation:	X		
a. A qualified health care professional reviews the inmate's health record	X		
b. If existing medical, dental, or mental health needs require accommodation, custody staff are notified	X		
c. The review and notification, if applicable, are documented in the health record	X		
2. The health professional's monitoring of a segregated inmate is based on the degree of isolation:	X		
a. Inmates in *solitary confinement* with little or no contact with other individuals are monitored daily by medical staff and at least once a week by mental health staff.	X		

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b. Inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or mental health staff.	X		
3. Documentation of segregation rounds is made on individual logs or cell cards, or in an inmate's health record, and includes:	X		
a. The date and time of the contact	X		
b. The signature or initials of the health staff member making the rounds	X		
4. Significant health findings are documented in the inmate's health record.	X		
5. Health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health.	X		
6. All aspects of the standard are addressed by written policy and defined procedures	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-G-03 Emergency Psychotropic Medication (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The policies on *emergency forced psychotropic medication*:	X		
a. Require licensed provider authorization prior to use	X		
b. Specify when, where, and how the psychotropic medication may be forced	X		
2. When a provider orders psychotropic medication to be forced, he or she documents in the patient's record:	X		
a. The patient's condition	X		
b. The threat posed	X		
c. The reason for forcing the medication	X		
d. Other treatment modalities attempted, if any	X		
e. Treatment plan goals for less restrictive treatment alternatives as soon as possible	X		

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3. Appropriate follow-up care is provided when medication is forced.	X		
4. Follow-up documentation is made by nursing staff at least once within the first 15 minutes, then every 30 minutes until transfer to an inpatient setting or the patient no longer requires monitoring.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
While policy is available to govern the elements in this standard, in practice such intervention is not used. Patients requiring this level of care are immediately transferred to the hospital.			
The following corrective action is required:			
None			

J-G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Actions (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Health staff are not involved in the collection of *forensic information*.	X		
2. Health staff do not participate in disciplinary action nor are compelled to provide clinical information solely for the purposes of discipline.	X		
3. Treatments and medications are never withheld as a form of punishment.	X		
4. Segregation and restraints are never clinically implemented as disciplinary action.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-G-05 Informed Consent and Right to Refuse (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All examinations, treatments, and procedures are governed by *informed consent* practices applicable in the jurisdiction.	X		
2. For procedures and medications that in the community setting would require informed consent, written documentation of informed consent is required.	X		
3. Any health evaluation and treatment refusal is documented and must include the following:	X		

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a. Description of the service being refused	X		
b. Evidence that the inmate has been informed of any adverse health consequences that may occur because of the refusal	X		
c. The signature of the patient	X		
d. The signature of a health staff witness	X		
4. If the patient does not sign the refusal form, it is to be noted on the form by a second health or custody staff witness.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
None			
The following corrective action is required:			
None			

J-G-06 Medical and Other Research (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Guidelines are in place that specify:	X		
a. The process for obtaining approval to conduct the research	X		
b. The steps to be taken to preserve the subject's rights	X		
2. When inmates who are participants in a community-based research protocol are admitted to the facility, procedures provide for:	X		
a. Continuation of participation	X		
b. Consultation with community researchers so that withdrawal from the research protocol is done without harming the health of the inmate	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance concern(s) or positive findings:			
Medical research does not occur at this facility. The policy governs the elements of this standard.			
The following corrective action is required:			
None			

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

August 28, 2018

(b)(6); (b)(7)(C) MD
500 12th St. SW 2nd Floor
Washington, Dc 20536

Dear (b)(6); (b)(7)(C)

The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC) met on August 24, 2018 to review the findings from a recent survey and to consider the accreditation status of Eloy Detention Center. The Committee voted to continue the accreditation of this facility with the following qualification: that compliance be demonstrated with all of the essential standards and at least 85% of the applicable important standards. Compliance should be documented in a report and submitted to NCCHC by January 2, 2019. Enclosed is the accreditation report for the facility, listing cited standards and recommendations for achieving compliance.

The Committee acknowledged the facility's significant level of compliance with a number of NCCHC standards. However, in order to maintain accreditation, it is important that you address the cited standards in a timely manner.

Following receipt of documentation and verification of compliance, a Certificate of Accreditation will be sent to the health services administrator, indicating the facility's accreditation status. Please let us know if we can be of any assistance.

Sincerely,

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RN, CCHP-RN
Vice President, Accreditation

Enclosure

cc: (b)(6); (b)(7)(C) MHA, CHE, Chief Executive Officer

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National Commission on Correctional Health Care

To Whom It May Concern:

NCCHC's Accreditation Committee has requested further verification of compliance with one or more standards in the enclosed report. Please take a moment to review the guidelines below for submitting corrective action to NCCHC. Following these guidelines will expedite the processing and review of the documentation. Please allow 60 to 90 days after submission for an update report to be returned to the facility. The accreditation staff are available to answer any questions you may have after reviewing the report and the corrective action requirements. We can be reached at 773-880-1460.

Submission of Corrective Action Guidelines

- **All documentation must be scanned and submitted on a thumb drive or a CD**
- Please organize and clearly label materials by the standard it is intended to address
- Documents should be in Word or PDF format and files should not be "zipped"
- **Please be sure to highlight relevant portions of documents: revisions to policies and procedures, screening/assessment forms, etc.**
- Clearly identify the *name of your facility* on the submission, rather than noting only a state name, corporate vendor, or system headquarters
- If we have not received corrective action by the noted deadline, NCCHC will contact the facility HSA
- Review your submission to ensure it is complete and addresses all standards with compliance issues
- Please send only the information that is requested (e.g., if corrective action requires specific protocols for G-01, send only the requested protocols and not others that may not be required by the standard)
- Remember, evidence of practice is key and implementation of a plan, study results, and other clear documentation of compliance is what NCCHC looks for to assess whether a standard is met
- We recommend that you send materials via FedEx, UPS, or another reliable delivery service that can be tracked
- **Due to the volume of incoming materials, we ask that you verify receipt through your delivery service rather than contact NCCHC**

Please submit the thumb drive or CD to:

National Commission on Correctional Health Care
ATTN: Accreditation Department
1145 W. Diversey Parkway
Chicago, IL 60614

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National Commission on Correctional Health Care

ACCREDITATION REPORT OF

THE HEALTH CARE SERVICES AT

ELOY DETENTION CENTER

Eloy, AZ

August 24, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

AMERICAN OVERSIGHT

Eloy Detention Center, AZ
August 24, 2018

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On May 31-June 1, 2018. NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2014 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 40 essential standards; 39 are applicable to this facility and 38 (97%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standard Not in Compliance
J-C-01 Credentials

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 25 (96%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standard Not in Compliance
J-F-02 Medical Diets

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: On August 24, 2018, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by January 2, 2019.

AMERICAN OVERSIGHT

Eloy Detention Center, AZ
August 24, 2018

I. Facility Profile

The facility's security classification is: Medium
The facility was built in: 1994
The facility's mission or purpose has not changed since the facility opened.
The facility is located in the Southwestern United States.
The facility's supervision style is: Direct Supervision.
The facility's structural layout is: Modular-Style Housing
There are no major renovations/expansions/closures anticipated.
Total Inmate Count on day of survey: 1440
Total number of adult males on day of the survey: 988
Total number of adult females on day of the survey: 453
Average Daily Population (ADP) for last completed calendar year: 1375
The design-rated capacity for the facility is: 1596
There hasn't been a substantial increase or decrease in the inmate population.
Admissions to the facility arrive: Unscheduled admissions
The total number of admissions to the facility last year was: 7104
The average daily intake to the facility last year was: 19
The total number of correctional staff assigned to this facility is (b)(7)(E)
The usual shift coverage for correctional staff is: (b)(7)(E)
There has been no change in the health care contractor: No
Health services are provided by the IHSC Immigration Health Service Corp
They have provided health services since: 2007
There have not been distinctive events that may affect the delivery of health care.
The facility has no satellites.

II. Survey Method

We toured the clinic area, inmate housing areas, segregation (Special Management Unit or SMU), health services, intake area, food service, library, school, inside activity rooms, and outside exercise area, We reviewed 39 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the wardens, health services administrator (HSA), clinical and medical directors, other health, dental and pharmacy staff, intake officer, compliance manager, 17 COs, and 15 inmates selected at random.

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III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Inmates have access to health care. Patients see a qualified clinician and receive care for their serious medical, mental health, and dental needs. There was no fee-for-service policy at the time of the survey. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is the Immigration Health Services Corp, whose on-site representative is the full-time HSA. Her responsibilities are outlined in a job description. Clinical judgments rest with a designated, full-time responsible physician. The clinical director is also on-site full-time. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding inmates' serious medical, dental, and mental health needs in the inmates' best interests. We noted excellent cooperation between custody and medical staff. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. The health staff is subject to the same security regulations as other facility employees. The standard is met.

J-A-04 Administrative Meetings and Reports (E). The department heads and warden meet monthly to discuss administrative matters with health staff and detention supervisors. Health staff meets quarterly to discuss health services operations. Attendees include the responsible physician, HSA, mental health, dental, and nursing staff. Statistical reports of health services are completed at least monthly, and are provided to the facility administrator and supervising health services administrators. These are used to monitor trends in the delivery of health care. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy and procedure manual was site-specific. The RHA and responsible physician review the manually annually, most recently on April 14, 2018. Policies such as those for custody, kitchen, or headquarters, do not conflict with health care policies, which we observed to be accessible to health staff. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee, which meets quarterly, consists of the CQI coordinator, responsible physician, clinical director, HSA, facility safety manager, mid-level providers, and medical records, mental health, and dental representatives. Other facility staff attends, if indicated. More than five site-specific studies have been completed annually since the last survey. Recent process studies examined medication administration records (MARs), continuity of care, suicide risk assessment, urgent care, dental care, grievances, asthma, diabetes, and special needs. We confirmed the studies

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consisted of a clearly identified problem, a baseline study, a corrective action plan that had been implemented, and results after restudying the effectiveness of the corrective action plan.

The responsible physician is involved in the CQI program. He attends the meetings, reviews charts, and helps determine trends and other areas for study. The program has been reviewed annually for its effectiveness, as well. The standard is met.

J-A-07 Emergency Response Plan (E). The RHA and facility administrator approved the health aspects of the emergency response plan, which included the required elements, on December 20, 2017. Multiple casualty disaster drills have been conducted and spanned each of the three shifts. The scenarios included a kitchen fire, an inmate fight, and a stabbing. Community agencies also participated. We confirmed the drills were critiqued and the results were shared with the health staff.

Man-down events had been documented and confirmed that health staff on each shift has been able to participate annually; we also confirmed these have been critiqued and the results shared with health staff.

Other measures taken at this facility include monthly fire drills. The HSA attends meetings of the Public Health, Safety, and Preparedness Committee. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health services staff with regard to inmates' special health needs occurs in writing and verbally. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters and discussion of patient information are conducted in auditory and visual privacy. Security personnel are present only if the patient poses a probable risk to the safety of the health care professional or others. Privacy screens are utilized, and a chaperone may be present in the exam room, if indicated. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there have been two inmate deaths, one due to natural causes and the other a suicide. The mortality reviews consisted of the required elements (including a psychological autopsy for the case of suicide), and were completed within 30 days. We verified that the findings had been shared with the staff. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the facility's formal grievance program. Inmates can also discuss their issues informally with a staff member before issuing a written grievance. Grievances are to be answered within five days. We found the responses to be timely. If necessary, inmates may appeal to the warden and a committee to resolve the problem. On an average, ten health-related grievances are filed per month. The standard is met.

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B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Prevention and Control Program (E). The responsible physician had approved the written exposure control plan, which has been updated annually, most recently on April 25, 2018. Infection control matters are addressed at the CQI, administrative, health and safety committee, and health staff meetings. The compliance officer and infection prevention nurse provide oversight and coordinate infection prevention and control practices at the facility. Patients with communicable diseases are housed in one of the four negative pressure rooms in the health care unit. These rooms are checked daily to assure proper functioning, while a contracted engineering company inspects them annually. Effective ectoparasite control procedures are used to treat infected inmates. The captain inspects the health services areas monthly for environmental concerns. An annual infection control risk assessment is also completed. The standard is met.

J-B-02 Patient Safety (I). The safety management plan/manual guides efforts to prevent adverse and near-miss clinical events, which we confirmed staff can report in a non-punitive environment. Safety issues are regular topics at the meetings of the health and safety and CQI committees, and health staff meetings. The standard is met.

J-B-03 Staff Safety (I). Health staff appeared to work under safe and sanitary conditions. The safety officer oversees all aspects of a safe environment. We also noted that all staff had been trained on workplace violence prevention. The standard is met.

J-B-04 Federal Sexual Abuse Regulations (E). The warden described the facility as compliant with the 2003 Federal Prison Rape Elimination Act (PREA). Written policies and procedures address the detection, prevention and reduction of sexual abuse, and staff undergoes annual training. The assistant deputy warden is responsible for PREA compliance at this facility. We reviewed the results of two federal PREA audits, both of which were successful. The standard is met.

J-B-05 Response to Sexual Abuse (I). Health staff had been trained in how to detect, assesses, and responds to signs of sexual abuse and sexual harassment, including evidence preservation. The Federal Bureau of Prisons' training is utilized during orientation and annual refresher units. Completion is documented electronically and in the employees' personnel files. Victims of sexual assault are referred to a community facility for treatment and evidence collection. In all cases, the victim is evaluated by a qualified mental health professional and a report is made to correctional authorities to effect a housing separation of the victim from the assailant. There have been no substantiated incidents of sexual assault since the last survey. The standard is met.

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C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentials (E). Health care personnel who provide services to inmates had credentials. Human resources staff is responsible for the monthly, on-going credential verification process, which includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank.

However, the physician assistants were providing services that were not consistent with the jurisdiction's licensure, certification, and registration requirements. All physician assistants need a current supervising physician to practice in this state. The paperwork approved by the Board of Medicine listed the supervising physician as someone no longer employed at the agency. New paperwork needed to be submitted for approval, and was initiated during the survey. **The standard is not met.**

> Corrective action is required for Compliance Indicator #3. Health professionals should not perform tasks beyond those permitted by their credentials. Acceptable documentation includes a plan by the RHA on how this standard has been corrected, including evidence that the physician assistants are properly supervised by a physician employed at the agency. In order to receive accreditation, verification that this standard has been met is required.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a log listing the names of the individuals being reviewed and the date of their most recent review, which included required elements. We also verified that the findings had been shared with them. If there were to be a concern about an individual's competency, a corrective action plan would be developed with that employee. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals had the required number of continuing education credits. All were current in cardiopulmonary resuscitation (CPR) training. We reviewed a list of completed courses and number of hours to confirm compliance, and noted that the state requires continuing education credits for license renewal for all of the professions employed at the facility. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff had the required training in health-related topics and almost all were current in their health-related training. All officers are required to participate in annual training as a condition of employment. We reviewed the training outline (including course content and length), and confirmed it included all the required topics. The standard is met.

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J-C-05 Medication Administration Training (E). Nurses administer medications. Medication administration is part of orientation and reviewed annually thereafter. This includes work with an on-the-job preceptor. Both trainings include a written test. We verified that the curriculum has been approved by the HSA and facility administrator, and included matters of security, accountability, common side effects, and documentation. The standard is met.

J-C-06 Inmate Workers (E). Inmate workers do not provide health services, nor are they involved in peer health-related programs. They may work in the kitchen or in a janitorial capacity, but do not handle bio-hazardous materials or clean such spills. We verified they had been trained on use of personal protective equipment, cleaning procedures, and general safety issues. We verified compliance by reviewing the training documentation, which both the inmates and officer signed. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

(b)(7)(E)

At the time of the survey, the following positions were vacant: (b)(7)(E)
The standard is met.

J-C-08 Health Care Liaison (I). Health staff is on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff had received the appropriate orientation by reviewing the completed checklists filed in the employees' files. We also confirmed that the HSA and facility administrator had reviewed the orientation lesson plan at least every two years, most recently on April 25, 2018. The standard is met.

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D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). The medical services includes an on-site pharmacy. Medications are either stored in the pharmacy, or in a locked medication room or locked medication cart. The narcotics are counted every shift and stored in a locked narcotic cabinet in the pharmacy. We verified the accuracy of the counts.

Orders are placed electronically, and dispensed in blister packs for the nursing staff to administer. Stock medications need to be signed out of a locked cabinet and counted each time to ensure adequate control of and accountability of all medications. Pharmaceuticals to be disposed of are secured in the pharmacy. The pharmacist inspects the medication administration areas and carts monthly. We reviewed the results since the last survey.

We observed all medications were stored under proper conditions and an adequate supply of antidotes and other emergency medications was readily available to staff. The pharmacy and therapeutics committee meets quarterly. While a formulary was in place, we verified that providers may order "off formulary," when clinically indicated. The medical director approves the non-formulary medication requests, generally within 24 hours. The standard is met.

J-D-02 Medication Services (E). Medication services are clinically appropriate and provided in a timely, safe, and sufficient manner. Most inmates come to the medication room's pill line. Medications are delivered to those that are housed in segregation. The policy defines the expected time frames from ordering to delivery, and a backup plan if the time frames cannot be met. During regular business hours, inmates will receive medication within 24 hours after the medication is prescribed by a provider. If it is unavailable, it is either taken out of the stock supply or obtained from a local pharmacy.

The responsible physician determines the prescriptive practices at this facility. Medications are prescribed only when clinically indicated. Inmates entering the facility on prescription medication continue to receive it or an acceptable alternative, as clinically indicated. Inmates may keep medications with a low abuse potential on their persons, and they must be reliable to comply with their orders. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes a medication room, examination rooms, office space for providers, an emergency room, a two-chair dental operatory, a lab area, a conference room, medical records storage, a waiting area, a pharmacy, an x-ray suite, a nursing station, and two negative pressure rooms. Items subject to abuse are inventoried each shift. We verified the accuracy of the counts, and confirmed that there were adequate supplies and equipment, including three automated external defibrillators. The standard is met.

J-D-04 Diagnostic Services (I). On-site diagnostic services include stool blood-testing material, finger-stick blood glucose tests, peak flow meters, multiple-test dipstick urinalysis, and pregnancy tests. X-rays are available on-site, while an off-site laboratory had been contracted to

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process specimens. We observed that lab and x-ray procedure manuals were available. The CLIA waiver was due to expire on October 20, 2018, and the dental x-ray machine was certified on January 30, 2020. The standard is met.

J-D-05 Hospital and Specialty Care (E). Hospitalization and specialty care is available to patients in need of these services. We verified through record review that off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions. No specialty services were provided on site at the time of the survey. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). Inmates receive verbal and written instructions in English and Spanish on access to health care services, and the health-related grievance procedures. Those who speak other languages or who have a hearing impairment can use an interpretation service. We observed an access-to-care sign had been posted at intake. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community. Reception personnel identify those individuals in need of emergency care and refer them immediately to a hospital or mental health facility for care. Their subsequent admission to the facility is predicated on a written medical clearance.

Nurses complete the receiving screening. An RN reviews a screening completed by an LPN. Receiving screening takes place immediately after inmates' arrival. We verified that it includes a disposition and addresses the required areas of inquiry. If a woman reports current opiate use, she is referred immediately for a pregnancy test. All pregnant women who are using opiates are immediately referred to the hospital. Prescribed medications are reviewed and appropriately maintained as clinically indicated. Health staff regularly monitors receiving screenings to determine the safety and effectiveness of the process as part of CQI efforts. The standard is met.

J-E-03 Transfer Screening (E). A transfer screening is performed by qualified health care on all intrasystem transfers immediately upon their arrival. Transfers receive the same intake screening as new admissions, and the record is reviewed to assure continuity-of-care. Medications, any necessary care, and referrals are provided. The review is documented in the EMR. The standard is met.

J-E-04 Initial Health Assessment (E). The full population health assessment has been implemented at this facility. All inmates receive an initial health assessment no later than 14 calendar days after admission. A trained RN or mid-level completes the health assessment, usually one or two days after arrival. We verified that the health assessment consists of the

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required elements, including a review of the receiving screening results, and laboratory or diagnostic tests for communicable diseases. TB skin tests are performed on all inmates. The treating clinician reviews all the positive findings. Specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem are developed as clinically indicated. The standard is met.

J-E-05 Mental Health Screening and Evaluation (E). A trained RN completes the mental health screening during the initial intake screening. We confirmed that it includes the required areas of inquiry. Patients with positive results are referred to qualified mental health professionals for further evaluation. Mental health professionals review all intakes. If the inmate's mental health needs cannot be met at the facility, they are immediately transferred to a mental health facility for treatment. The standard is met.

J-E-06 Oral Care (E). Midlevel providers and trained RNs complete the oral screening during the health assessment. Inmates are instructed in oral hygiene and preventive oral education upon intake, and the dentist completes an oral examination within 12 months of their admission. We found oral care to be timely and confirmed it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment was not limited to extractions. An oral surgeon is available for referrals and can provide emergency treatment. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). All inmates, regardless of housing assignment, have access to regularly scheduled times for routine health care. The frequency and duration of response to requests for health services was sufficient for the inmate population. The inmate walks in to be seen in sick call in the morning. They can address urgent/emergent needs with an officer, who calls health services, or walk into health services at any time. Nursing guidelines are utilized. If a referral to a provider is indicated, the inmate is scheduled for the next business day, or they are seen immediately, if urgent. The standard is met.

J-E-08 Emergency Services (E). The RHA maintains emergency drugs, supplies, and medical equipment, which are checked each shift. Inmates are taken to the hospital by ambulance or facility van. The emergency facility is ten minutes away. Emergency on-call services were available as well. The standard is met.

J-E-09 Segregated Inmates (I). There were 40 men's segregation cells, and three women's cells, at the time of the survey. Before being segregated, inmates are brought to health care for a face-to-face assessment to determine if there are any contraindications or special accommodations needed.

Conditions of segregation at this facility meet NCCHC's category b. This requires health rounds at least three times per week; in practice, health rounds are conducted daily, and mental health rounds weekly. We verified that the rounds are documented in the medical record, on a door card, and in a logbook. Health staff informs custody officials of the latest scientific information concerning the health effects of segregation during the administrative meetings. The standard is met.

J-E-10 Patient Escort (I). Patients are escorted to on-site and off-site clinical appointments in a timely manner. Transporting officers are alerted to special accommodations, such as medication

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administration. The patient's confidentiality is maintained during the period of transfer. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols (Nursing Guidelines) are utilized. These do not include prescription medications, except epinephrine in an emergency, and a subsequent provider's order is obtained. The responsible physician and nursing administrator last reviewed the protocols on April 25, 2018. We verified that the nurses are trained to use the protocols upon hire and when they are revised or introduced. We also verified they undergo annual reviews of competency. Proper use of the protocols has also been a topic of CQI studies. The standard is met.

J-E-12 Continuity and Coordination of Care During Incarceration (E). We confirmed that continuity of care is appropriate. Clinician orders are evidence-based and implemented in a timely manner. Deviations are clinically justified, documented and shared with the patient. The clinician review diagnostic tests in a timely manner, and they are appropriately acted upon. Treatment plans are modified as clinically indicated as well.

Patients receive treatment and diagnostic tests ordered by clinicians, who discuss such care with them. When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard. The clinicians review and act upon specialty consultants' recommendations in a timely manner.

The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations (Bureau of Prisons). Chart reviews were of sufficient frequency and number to assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is met.

J-E-13 Discharge Planning (E). The nursing staff and HSA are involved in discharge planning, which includes arranging for a two-week to 30-day supply of medication, and appointments for those inmates requiring follow-up after discharge. All inmates also leave with a discharge summary, and a list of referral sources. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). The RHA utilizes the National Health Education Manual for inmate health education. We observed a variety of health-related brochures and pamphlets were generally available. Individual health education and instruction in self-care was documented in the health record during clinical encounters. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 185 medical diets were being prepared for patients with specific dietary needs. Inmates who refuse prescribed diets receive receive follow up nutritional counseling. Workers who prepare medical diets are trained and supervised while doing so. A "heart healthy" diet was being served at the time of the survey.

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However, a registered dietitian reviews the medical diet menus annually, most recently on June 29, 2017, rather than semi-annually. **The standard is not met.**

> Corrective action is required for Compliance Indicator #2. A registered or licensed dietitian should review medical diets for nutritional adequacy at least every six months, and whenever a substantial change in the menu is made, through a documented on-site visit or by written consultation. The following is acceptable documentation for compliance: (a) evidence that reviews will take place at least every six months; and (b) a copy of the most recently dietitian approved and signed medical diet menu. Corrective action is required in order to meet this standard.

J-F-03 Use of Tobacco (I). Smoking is prohibited at this facility. We observed literature on the hazards of tobacco to be available to the inmates. The standard is met.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appeared in compliance with current community standards. The responsible physician had established and annually approves clinical protocols, consistent with national clinical practice guidelines, which we verified included the nine required disease entities. The protocols were last reviewed in March 2018. We verified that the guidelines were in use at the time of the survey.

The treatment plans included all the appropriate elements: frequency of follow-up, monitoring condition and status and taking action as indicated; type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medication and adaptation to correctional environment, and clinical justification of deviation from the protocols. Chronic illnesses were listed on the problem list, and we confirmed that the RHA maintains a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health condition(s) of the patient, multi-disciplinary treatment plans define the individual's care, and include the frequency of follow-up; type and frequency of diagnostic testing and therapeutic regimens; and instructions about diet, exercise, medication, and adaptation to the correctional environment. Special needs were listed on the problem list, and we confirmed that the RHA maintains a list of special needs patients. The standard is met.

J-G-03 Infirmary Care (E). There was no infirmary at the time of the survey. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Patients with mental health needs are either followed by the psychiatrist every 30 days or as clinically indicated, if they are on psychotropic medication, or by mental health workers if they are not. When clinically appropriate, a patient's commitment or transfer to an inpatient psychiatric setting is timely (within hours), and

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accomplished according to procedures. Health services are integrated for patient management and to ensure their medical and mental health needs are met.

Basic on-site outpatient services include the identification and referral of inmates with mental health needs, crisis intervention services, psychotropic medication management when indicated, individual counseling, group counseling, psychosocial/psychoeducational programs, and treatment documentation and follow-up. The standard is met.

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence. Patient follow-up occurs as clinically indicated. Mental health staff must see the inmate within 24 hours of his or her placement on precautions, which only mental health staff can continue.

The suicide prevention program was revised in 2016, after a completed suicide. All inmates are placed on one-on-one observation, whether considered acute or non-acute. An officer also documents observations at staggered intervals. Acutely suicidal inmates are placed on constant observation in a "safe cell," until they can be transferred to a mental health facility.

The whole suicide program was revised in 2016, after a successful suicide. All inmates are placed on constant monitoring, and the officer documents checks at staggered intervals not exceeding 15 minutes. If an inmate were to make an attempt, they would be transferred to a more appropriate/therapeutic setting. The standard is met.

J-G-06 Patients with Alcohol And Other Drug Problems (AOD) (E). Disorders associated with AOD, such as HIV and liver disease, are recognized and treated. Correctional staff had been trained to recognize inmates' AOD problems. Medical, mental health, and substance abuse staff communicates and coordinates with each other regarding patients' AOD care. Self-help substance abuse programs, individual counseling and group therapy are offered on site as well. The standard is met.

J-G-07 Intoxication and Withdrawal (E). Detoxification and withdrawal is not provided at this facility. Any inmate requiring detoxification or experiencing withdrawal is assessed (using protocols and a screening tool), and would be sent to the hospital for care. The inmate would be discharged back to the facility when they are stable.

If a pregnant inmate is admitted with opioid dependence, she is transferred to the hospital for assessment and treatment. The facility's policy addresses the management of inmates, including pregnant inmates, on methadone or similar substances. Arrangements would be made to transfer the pregnant inmate to another facility for appropriate care and follow-up.

The protocols were lasted approved by the physician on July, 20, 2017. The standard is met.

J-G-08 Contraception (I). Emergency and continuing contraception is offered and can be obtained from the pharmacy. We observed written information about contraception methods and community resources to be available. The standard is met.

J-G-09 Counseling And Care Of The Pregnant Inmate (E). Pregnant inmates are housed at this facility. Counseling (by an off-site provider) and assistance are offered in accordance to the

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inmate's wishes. Their pre-natal and postpartum care is provided by an off-site obstetrical/gynecological specialist. Pregnant inmates would be transferred to the hospital to deliver. At the time of the survey, there were four pregnant women. The standard is met.

J-G-10 Aids to Impairment (I). We observed inmates using wheelchairs, canes, hearing aids, and other forms of assistance, during the tour. Health records documentation also indicated aids are provided as necessary. Nothing had been contraindicated for security reasons. Patients' special needs accommodations are communicated to custody staff in writing. The standard is met.

J-G-11 Care for the Terminally Ill (I). Although it would be rare for a terminally ill patient to be held at this facility, procedures were in place to make the appropriate accommodations, including discharge or transfer to a more appropriate setting. We confirmed there were policies and procedures to direct staff on caring for this type of patient. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Inmates' medical and mental health records are integrated into the electronic medical record, which is available to all health staff. We verified that all the essential elements were present. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are password-protected, with backups secured in the medical records room. Health and health staff both had documented instruction in maintaining patient confidentiality as part of orientation and annually thereafter. If non-health staff transports health records, the records are sealed in an envelope. Custody staff also signs a confidentiality statement. The standard is met.

J-H-03 Management of Health Records (I). When an inmate is transferred to another facility, copies of the current health record or a comprehensive health summary accompanies him/her. The system maintains all medical records indefinitely, and we confirmed they can be re-activated when the inmate re-enters the system. The standard is met.

J-H-04 Access to Custody Information (I). Qualified health care professionals have access to information in the inmate's custody record when such information may be relevant to the inmate's health and course of treatment. The standard is met.

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DHS-ICE-20-0618-A-001449

Eloy Detention Center, AZ
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I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). Neither clinical nor custody restraints are used at this facility. Anyone requiring restraints would be sent to another facility.

Seclusion has been used twice in the last three years. The inmate would be placed on a constant observation and assessed by a nurse or mental health staff member every 15 minutes (in addition to an initial assessment). The inmate must be of harm to himself or others for seclusion to be implemented; s/he is removed from seclusion as quickly as possible. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). Such intervention had been implemented once since the last survey. It was administered as a one-time dose. We verified that the documentation was appropriate. The policy and procedure were appropriate. The standard is met.

J-I-03 Forensic Information (I). Health staff does not collect forensic information; rather, the patient is sent off-site for collection. The standard is met.

J-I-04 End-of-life Decision Making (I). Patients approaching the end of life (less than one year to live) are permitted to execute advance directives, and after being counseled as to the meaning and consequences of such actions. This is documented in the health record. Such directives are reviewed by the deputy director of clinical services. In practice, terminally ill patients are not housed at this facility; they would be discharged or transferred to another facility. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). All informed consents and refusals of care are documented and consist of the required elements, including the signatures of the patient and a health staff witness. Patients are counseled as to possible adverse consequences to health that may occur as a result of a refusal. If the inmate refuses to sign a refusal form, two staff members (one of whom must be from health services) would sign as witnesses. The standard is met.

J-I-06 Medical and Other Research (I). Medical research does not take place at this facility. If an inmate were to arrive who was part of a community-based research project, the case would be reviewed by the Institutional Review Board to consider his or her continued participation. Federal regulations would guide the decision. The standard is met.

AMERICAN OVERSIGHT

TRINITY SERVICES GROUP, INC

Nutrition Adequacy Statement
Eloy Detention Center

The cycle menu, dated June 29, 2017, for this facility was developed by Trinity Services Group, based on specifications and guidelines from CoreCivic, to be served as the regular menu in the adult population. The menu has been reviewed, analyzed and approved, using the NetMenu Nutritional Analysis program from the CBORD Group, Inc. of Ithaca, New York. Per standard nutritional analysis protocol, the menu was averaged in seven-day periods.

The analysis confirms that the menu provides a nutritionally adequate diet for sedentary and/or incarcerated adults. As written and analyzed, the regular menu and common fare alternate menu satisfies the Dietary Reference Intakes/EARs recommendations published by the National Academy of Sciences-National Research Council for major nutrients recommended for adults. The menu also meets ACA standards for basic nutritional requirements.

Some nutrient values may vary based on the nutrient data available from manufacturers, the nutrient listings available under FDA labeling requirements, and the specified items used for analysis.

The therapeutic diets for this facility have been developed, using the master general population menu as a base and modified as necessary to meet the criteria for each diet, have been reviewed. The planned diet menus meet the requirements, as outlined in the approved diet manual, for the therapeutic diets utilized at this facility.

(b)(6); (b)(7)(C) RD

(b)(6); (b)(7)(C) RD 6/29/17

Registered Dietitian

AMERICAN OVERSIGHT

TRINITY SERVICES GROUP, INC.

Nutrition Adequacy Statement
Eloy Detention Center

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The therapeutic diets for this facility have been developed, using the master general population menu as a base and modified as necessary to meet the criteria for each diet, have been reviewed. The planned diet menus meet the requirements, as outlined in the approved diet manual, for the therapeutic diets utilized at this facility.

(b)(6); (b)(7)(C) RD

(b)(6); (b)(7)(C) RD 6/29/18

Registered Dietitian

AMERICAN OVERSIGHT



National Commission on Correctional Health Care

ACCREDITATION UPDATE REPORT OF

THE HEALTH CARE SERVICES AT

LASALLE DETENTION CENTER

Jena, LA

October 23, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

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DHS-ICE-20-0618-A-001453

LaSalle Detention Center, LA
October 23, 2018
UPDATE REPORT

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On July 19-21, 2017 NCCHC conducted its review for continuing accreditation of the LaSalle Detention Center under the NCCHC *2014 Standards for Health Services in Jails*. On November 5, 2017, NCCHC granted continuing accreditation with verification. The RHA subsequently submitted corrective action that brought the facility into compliance with additional standards. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's reports of November 5, 2017 and May 9, 2018.

There are 40 essential standards; 39 are applicable to this facility and 35 (90%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. ***The LaSalle Detention Center has not met this condition.***

Essential Standards Not in Compliance
J-A-04 Administrative Meetings and Reports
J-A-07 Emergency Response Plan
J-E-04 Initial Health Assessment
J-E-07 Nonemergency Health Care Requests and Services

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 24 (92%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. **The LaSalle Detention Center has met this condition.**

Important Standards Not in Compliance
J-C-02 Clinical Performance Enhancement
J-C-09 Orientation for Health Staff

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: NCCHC's Accreditation Committee voted to continue the facility's Continuing Accreditation with Verification (CAV) status, contingent upon receiving requested compliance verification by November 26, 2018.

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J-A-04 Administrative Meetings and Reports (E). The warden, AFOD, and HSA meet monthly to discuss administrative matters. We were informed that health staff meet monthly to discuss health services operations but were unable to validate this by evidence of staff meeting minutes. Attendees include the responsible physician, HSA, mental health staff, and nursing staff. Statistical reports of health services are made at least monthly and provided to headquarters staff, but not to the facility administrator. These reports are used to monitor trends in the delivery of health care. The standard is not met.

Corrective action is required for Compliance Indicator #3. Health staff meetings, held monthly or more frequently, give the health staff an opportunity to receive current information on all aspects of the institution's health care delivery.(b)(5)

(b)(5)

Corrective action is required for Compliance Indicator #4. Statistical reports of health services should be made at least monthly and provided to the facility administrator. The

(b)(5)

In March 2018, the RHA submitted several meeting minutes and attendance rosters dated 2014, 2015, 2016, 2017, and 2018 (one set of meeting minutes for the latter three years). Dating on the documentation was inconsistent, and it was difficult to confirm exact dates. The submission was not sufficient to confirm that health staff consistently meet monthly, as required.

The RHA also submitted "TRIAD" meeting minutes (indicating attendance by the warden), dated November 2017 and January and February 2018 where the monthly statistics were discussed. Further corrective action is required. The standard is not met.

In July 2018, the RHA submitted evidence of monthly health staff meetings from October 2017 through May 2018 (including lists of attendees). Additional "TRIAD" meeting minutes, or other documentation to confirm the facility administrator receives monthly health services statistics was not evident, and required for full compliance. **The standard is not met.**

J-A-07 Emergency Response Plan (E). Two multiple casualty disaster drills have been held annually so that over the course of three years, staff on each shift has had an opportunity to participate (health staff works 12-hour shifts). The scenarios included: a tornado hitting the facility involving community agencies and an actual tornado that passed by the facility. The drills have been critiqued and the results were shared with the health staff. Man-down drills have been held so that health staff on each shift has been able to participate annually. The man-down drills have been critiqued and the results were shared with all health staff.

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The RHA has approved the health aspects of the emergency response plan, which includes the required elements, although the facility administrator had not. The standard is not met.

Corrective action is required for Compliance Indicator #1. (b)(5)

(b)(5)

In March 2018, the RHA submitted a documented entitled 2016 Emergency Plan, which appears to be an executive plan and summary of a tornado strike. It is unclear how this is intended to address the facility's administrator's approval of the plan. The standard is not met.

In July 2018, the RHA submitted the June 2018 General Emergency Response Plan, which, while it did include a brief section entitled "Emergency Medical Aid Station," generally addresses security concerns during an emergency event. The RHA also submitted a memo (initialed by the warden) stating that the warden was aware of ICE Health Service Corp.'s policies and procedures regarding medical care, to include medication administration and emergency response plan. An emergency plan that addresses the requirements of the standard, and has been approved by the facility administrator as well as the responsible health authority, is required for full compliance. **The standard is not met.**

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a log listing the names of the individuals being reviewed and the date of their most recent review, which included required elements; however, eight of the 11 registered nurses and five of the 10 licensed practical nurses had no evidence of a current review. The standard is not met.

Corrective action is required for Compliance Indicator #1. (b)(5)

(b)(5)

In March 2018, the RHA indicated the nurse manager resigned before all the peer reviews were completed; peer reviews for the nursing staff were underway for the new fiscal year at the time of the submission. The submission included a list of reviews completed in 2016, but nothing indicating any reviews were completed in 2017. Verification that all nurses have received a clinical

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performance review, with all the required components (name and credentials of the reviewer and verification the results had been shared with the nurse in question) is required for full compliance. The standard is not met.

No further corrective action was received. **The standard is not met.**

J-C-05 Medication Administration Training (E). Nursing staff administer medications. They are trained upon hire and review it annually thereafter. We confirmed it includes matters of security, accountability, and documentation.

However, while the RHA has approved it, the facility administrator has not. The training material also does not address side effects. The standard is not met.

Corrective action is required for Compliance Indicator #1 and #2. (b)(5)

(b)(5)

In March 2018, the RHA indicated that the medication administration training is developed and approved at IHSC headquarters. A copy of the policy and procedure was provided and includes the requirements for training.

However, the training content did not address common side effects and there was no evidence of approval by the facility administrator. Further corrective action is required. The standard is not met.

In July 2018, the RHA submitted the power point outline from ICE (which includes common side effects), and the memo from ICE Health Services Corp (see J-A-07 Emergency Response Plan). **The standard is now met.**

J-C-09 Orientation for Health Staff (I). We confirmed that health staff has received the appropriate orientation by reviewing the computer attendance log.

However, there was no evidence of the last review or approval by the RHA and facility administrator. The standard is not met.

Corrective action is required for Compliance Indicators #1 and #2. (b)(5)

(b)(5)

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In March 2018, the RHA indicated at all employees complete 80 hours of training, which is documented on a checklist and filed appropriately. The RHA also indicated that refresher training has been requested on various correctional aspects. However, approval of the training by the RHA and facility administrator, and a plan to ensure it is reviewed and approved at least every two years was not evident. The standard is not met.

No further corrective action was received. **The standard is not met.**

J-E-04 Initial Health Assessment (E). The full population has been implemented at this facility. All inmates receive an initial health assessment generally within 10 days of admission. A trained registered nurse or nurse practitioner completes the hands-on portion of the health assessment. The health assessment consists of all the required elements, including laboratory or diagnostic tests for communicable diseases when indicated. The treating clinician reviews all positive findings. Specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem is developed as clinically indicated.

However, a review of the receiving screening results was not consistently documented. The standard is not met.

Corrective action is required for Compliance Indicator #2a. (b)(5)

(b)(5)

In March 2018, the RHA indicated that the compliance officers reviews charts to ensure that the screening results are read and used by providers during their examinations, and submitted a sample indicating the prescreening results had been reviewed. It was not clear what corrective action was taken regarding this issue, nor was a CQI study submitted as required. The standard is not met.

In July 2018, the RHA submitted the ICE Health Service Corp's intake screening and physical examination/health appraisal forms (both blank), and what was described as a CQI study (dated fourth quarter of 2017) of 10 records for 13 measures; however, the measures were not identified, so compliance with review of receiving screening results during the health assessment could not be verified. The latter form does include space to document that the intake screening was reviewed. Further corrective action is required to clarify what corrective action was taken, as well as a CQI study confirming its effectiveness regarding health assessment review of intake screenings. **The standard is not met.**

J-E-06 Oral Care (E). A trained registered nurse or nurse practitioner completes the oral screening during intake and the initial health assessment, generally within 10 days. The dentist completes an oral examination within 12 months of inmates' admission. Oral care is timely and it includes immediate access for urgent or painful conditions. The dentist has developed a system of established priorities for oral treatment, not limited to extractions.

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However, we could not confirm that inmates are instructed in oral hygiene and preventive oral education within one month of admission. The standard is not met.

Corrective action is required for Compliance Indicator #2. (b)(5)

(b)(5)

In March 2018, the RHA submitted the handout which includes dental care instructions, but a CQI study confirming that this information is consistently provided to inmates upon intake, or at least within 30 days of admission, was not included. The standard is not met.

In July 2018, the RHA submitted a CQI study (dated fourth quarter of 2017) of 10 records, which indicated that all 10 had documented health education regarding dental hygiene. **The standard is now met.**

J-E-07 Nonemergency Health Care Requests and Services (E). All inmates, regardless of housing assignment, have access to routine health care. Inmates sign up in their housing units; the sign-up sheet consists of their name and identification number and is retrieved at 5:00 a.m. Sick call takes place in either the main medical clinic or the dormitory exam rooms.

When a provider visit is necessary, clinical need dictates timing. However, triage occurs when the inmate is seen, which may take up to three days or more after signing up for sick call (a day's sick call list oftentimes is not completed the same day, and "rolled over" to the next day, thereby creating a backlog of requests that are not triaged until the inmate is actually seen. The standard is not met.

Corrective action is required for Compliance Indicator #1 and #4. (b)(5)

(b)(5)

In March 2018, the RHA indicated that additional staffing has enabled the backlog to be eliminated and all detainees to be seen. Dedicated sick call nurses will be assigned to make rounds to every dorm, every day, as well. The submission included a log that consisted of some of the required elements (inmate name/number, date received, date seen, and nurses' comments). While the log indicated that inmates were seen the same day or next as the request was received, it could not

AMERICAN OVERSIGHT

be determined when the request was submitted. Further, the nurses' comments column, while generally seeming to indicate the nature of the request, was blank in a number of examples. Finally, the submitted log documented for only a few days in February 2018 (February 2, and February 26-28, for a total of approximately a dozen entries). Further corrective action is required, including a 60-day log that consists of all the required elements. The standard is not met.

In July 2018, the RHA submitted evidence of staff training on sick call processes (although it was not dated), and sick call logs. However, it was difficult to confirm consistent compliance; the individual pages were dated at the top (although frequently not clearly due to holes having been punched in the same location in order to file the pages in a binder), and it is unclear what date this signifies. The table itself consisted of the same elements as described in the March 2018 submission of corrective action; however, there were numerous blanks for "date received," so it was difficult to assess the timeliness of the sick call process. Further logs (at least 30 days) consisting of the required elements (inmate number, date of request, nature of complaint, date of triage, and date of face-to-face assessment by qualified health care professional) should be submitted. **The standard is not met.**

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

April 24, 2018

(b)(6); (b)(7)(C) MD
500 12th St. SW 2nd Floor
Washington, DC 20536

Dear (b)(6); (b)(7)(C)

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on April 22, 2018, voted to continue to accredit Houston Contract Detention for its compliance with NCCHC's *Standards for Health Services in Jails*. Please find the accreditation report. Your health services administrator will also receive a copy of the accreditation report and the Certificate of Accreditation.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to February 1, 2021. If we can be of any assistance to you, please feel free to contact us.

Sincerely,

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RN, CCHP-RN
Vice President, Accreditation

Enclosure

cc: (b)(6); (b)(7)(C) MHA, CHE, Chief Executive Officer
(b)(6); (b)(7)(C)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001461

National Commission on Correctional Health Care

ACCREDITATION UPDATE REPORT OF

THE HEALTH CARE SERVICES AT

HOUSTON CONTRACT DETENTION

Houston, TX

April 22, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

AMERICAN OVERSIGHT

Houston Contract Detention, TX
April 22, 2018

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On February 12- 14, 2018, NCCHC conducted its review for continuing accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2014 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 40 essential standards; 39 are applicable to this facility and 39 (100%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance
None

Essential Standards Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 25 (96%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standard Not in Compliance
J-F-02 Special Diets

Important Standards Not Applicable
J-G-08 Health Care Liaison

Decision: On April 22, 2018, NCCHC's Accreditation Committee awarded the facility Accreditation.

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Houston Contract Detention, TX
April 22, 2018

I. Facility Profile

The facility's security classification is: Medium
The facility was built in: April 1984 and expansion was completed July 2005
The facility's mission or purpose has not changed since the facility opened.
The facility is located in the Southwestern United States.
The facility's supervision style is: Direct Supervision.
The facility's structural layout is: Dormitory-Style Housing
No major renovations/expansions/closures were anticipated at the time of the survey.
Total Inmate Count on day of survey: 918
Total number of adult males on day of the survey: 767
Total number of adult females on day of the survey: 151
Average Daily Population (ADP) for last completed calendar year: 904
The design-rated capacity for the facility is: 1000
There hasn't been a substantial increase or decrease in the inmate population.
Admissions to the facility arrive: unscheduled and at any time of day.
The total number of admissions to the facility last year was: unavailable
The average daily intake to the facility last year was: unavailable
The total number of correctional staff assigned to this facility is: unavailable
The usual shift coverage for correctional staff is: unavailable
There has been no change in the health care contractor: No
Health services are provided by Immigration and Customs Enforcement Health Service Corps (IHSC)
They have provided health services since: 1984
There have not been distinctive events that may affect the delivery of health care.
The facility has no satellites.

II. Survey Method

We toured the clinic area, detainee housing areas, segregation (Special Management Unit), health services, intake area, food service, library, school, inside activity rooms, and outside exercise area, We reviewed 20 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the warden, health services administrator (HSA),facility medical director, other health, dental, mental health, and pharmacy staff, intake officer, laundry officer, three COs, and nine detainees selected at random.

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Houston Contract Detention, TX
April 22, 2018

III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Inmates have access to health care. Patients see a qualified clinician and receive care in a timely manner as ordered for their serious medical, mental health, and dental needs. There was no fee-for-service program in place at the time of the survey. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is IHSC. The on-site representative is the full-time HSA, whose responsibilities are outlined in a job description. Clinical judgments rest with a designated, full-time responsible physician. The clinical director is also full-time. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding detainees' serious medical, dental, and mental health needs in the inmates' best interests. We noted excellent cooperation between custody and medical staff. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. The health staff is subject to the same security regulations as other facility employees. The standard is met.

J-A-04 Administrative Meetings and Reports (E). The department heads and warden meet monthly to discuss administrative matters with health staff, and detention supervisors. Health staff also meets monthly to discuss health services operations. Attendees include the responsible physician, HSA, mental health, dental, and nursing staff. Statistical reports of health services are completed at least monthly, and are provided to the facility administrator and health services administrators. They are used to monitor trends in the delivery of health care. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy and procedure manual is site-specific. The RHA and responsible physician review them annually, most recently in March 2017. Other policies, such as those for custody, kitchen, or headquarters, do not conflict with health care policies. We confirmed the policies were accessible to health staff. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee, which meets quarterly, consists of the CQI nurse, responsible physician, clinical director HSA, safety manager, mid-levels, medical records, mental health, and dental representatives; other staff attends as needed. More than 15 site-specific studies have been completed since the last survey. Recent process studies examined, medications, continuity of care, suicide watch, urgent care, dental care, grievances, and intake screening. When the results did not meet threshold,

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new plans were developed and implemented, and the topic re-audited. We confirmed the studies consisted of a clearly identified problem, a baseline study, a corrective action plan that had been implemented, and the results after restudying the effectiveness of the corrective action plan. A patient satisfaction survey was also conducted. The results were very positive.

The responsible physician is involved in the CQI program. He attends the meetings, reviews charts, and helps determine trends and areas for further study. The program is reviewed for its effectiveness during the new year's first CQI meeting. The standard is met.

J-A-07 Emergency Response Plan (E). The RHA and facility administrator have approved the health aspects of the emergency response plan (March 2017), which includes the required elements. Multiple casualty disaster drills were conducted. The scenarios included a roof collapse, a tornado, and a fire. All staff from the three shifts participated, as did representatives from community agencies. We confirmed that the drills were critiqued, and the results were shared with the health staff.

Man-down events were documented and confirmed that health staff on each shift has been able to participate. We also verified that these have been critiqued and the results were shared with all health staff. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health services staff with regard to inmates' special health needs occurs in writing and verbally. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters and discussion of patient information are conducted in auditory and visual privacy. Security personnel are present only if the patient poses a probable risk to the safety of the health care professional or others. Methods used to ensure patient privacy include privacy screens and a chaperone, as indicated. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there has been one death (natural causes). The mortality review was conducted within 30 days, and the findings were shared with the staff. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the facility's formal grievance program. Detainees may informally discuss their issues with a health staff member before writing a formal grievance. A response is due in five days. If necessary, detainees may appeal to the warden and a committee to resolve the issue. On average, three health-related grievances are filed per month. The responses are timely. The standard is met.

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B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Prevention and Control Program (E). The responsible physician has approved the written exposure control plan. It is updated annually, most recently on March 1, 2017. Infection control matters are addressed at the CQI, health and safety committee, administrative and staff meetings. The compliance officer and infection prevention nurse provide oversight and coordinate infection prevention and control efforts. Patients with communicable diseases are housed in one of the four negative pressure rooms in the health unit. These are checked daily to assure proper functioning, and an engineering company inspects annually. Effective ectoparasite control procedures are used to treat infected inmates. The captain inspects the health services areas monthly for environmental concerns. The infection control risk assessment is also completed annually. The standard is met.

J-B-02 Patient Safety (I). The safety management plan/manual provides guidance in preventing adverse and near-miss clinical events, which staff can report in a non-punitive environment. Any such issues are discussed at the health and safety committee, CQI and staff meetings. The standard is met.

J-B-03 Staff Safety (I). Health staff appears to work under safe and sanitary conditions. The safety officer oversees all aspects of a safe environment. All staff had been trained on workplace violence prevention as well. The standard is met.

J-B-04 Federal Sexual Abuse Regulations (E). The warden described the facility as compliant with the 2003 Federal Prison Rape Elimination Act (PREA). The assistant deputy warden is responsible for PREA compliance at this facility. Written policies and procedures address the detection, prevention and reduction of sexual abuse, and the training is reviewed annually. The standard is met.

J-B-05 Response to Sexual Abuse (I). Health staff had been trained in how to detect, assesses, and responds to signs of sexual abuse and sexual harassment, as well as evidence preservation. The Federal Bureau of Prisons' training is utilized, during orientation and annual review. We verified that training is documented electronically and in the personnel file. Victims of sexual assault are referred to a community facility for treatment and evidence collection. In all cases, the victim is evaluated by a qualified mental health professional, and a report is made to correctional authorities to effect a housing separation of the victim from the assailant. There have been no substantiated incidents of sexual assault since the last survey. The standard is met.

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C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentials (E). Health care personnel who provide services to inmates had credentials and were providing services consistent with the jurisdiction's licensure, certification, and registration requirements. Human Resources staff is responsible for the monthly, on-going credential verification process. The credential verification process includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank. The standard is met.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a log listing the names of the individuals being reviewed and the date of their most recent review, which included required elements. We confirmed that all findings are reviewed with the employee. If there is a concern about an individual's competency, a corrective action plan is developed with that employee. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals had the required number of continuing education credits. All were current in cardiopulmonary resuscitation (CPR) training. The state requires continuing education credits for license renewal, for all of the professions employed at the facility. We confirmed compliance by reviewing a list of completed courses and number of hours. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff had the required training in health-related topics, and all were current in their health-related training. This is a condition of employment. We reviewed the training outline including course content and length and confirmed it included all the required topics. The standard is met.

J-C-05 Medication Administration Training (E). Nurses administer medications. They are trained during orientation which includes on-the-job training with a preceptor and annually thereafter. The training also includes a written test. It is documented electronically and in the personnel files. We verified the HSA and facility administrator have approved the training curriculum, which includes matters of security, accountability, common side effects, and documentation. The standard is met.

J-C-06 Inmate Workers (E). Detainee workers do not provide health services, nor are they involved in any peer health-related programs. They may work in the kitchen or in a janitorial capacity. A civilian employee cleans the health unit. Detainee workers do not handle bio-hazardous materials or clean such spills. We verified that they are trained on the use of personal protective equipment, and general cleaning instructions. The training is documented in writing. The standard is met.

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J-C-07 Staffing (I). Full-time equivalent health staff includes:

(b)(7)(E)

At the time of the survey, there no vacancies. The standard is met.

J-C-08 Health Care Liaison (I). Health staff is on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff had received the appropriate orientation via a signed check list in each employee's personnel file. The HSA and facility administrator review the lesson plan at least every two years. The orientation lesson plan is reviewed at least once every two years, most recently on October 8, 2017. Employees receive three weeks of administrative orientation and four-six weeks of discipline-specific training, with a preceptor. The standard is met.

D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). The on-site pharmacy provides pharmaceutical services that are sufficient to meet the needs of the detainees. Medications are either stored in the pharmacy, or in the medication room or medication cart, both of which are locked. The narcotics are secure in a locked cabinet and safe in the pharmacy. We confirmed they are counted every shift. We verified the counts were correct. Medications are ordered electronically and dispensed to nursing staff in blister packs. Pharmaceuticals needing disposal are secured in the pharmacy until they are destroyed. The pharmacist inspects the medication area and carts quarterly. We confirmed this has been consistent since the last survey. Stock medications

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need to be signed out of a locked cabinet, and are counted each time one is removed to ensure adequate control of and accountability of all medications. We verified that medications were stored under proper conditions, and an adequate supply of antidotes and other emergency medications was readily available to staff. The Pharmacy and Therapeutics Committee meets quarterly. We also confirmed a formulary was in place, and providers may order "off formulary," if necessary. The standard is met.

J-D-02 Medication Services (E). Medication services are clinically appropriate and provided in a timely, safe and sufficient manner. Medications are delivered at a pill line for most detainees, while they are delivered to segregated detainees. The policies identifies the expected time frames from ordering to delivery, and a backup plan if the time frames cannot be met. A detainee will receive medication within 24 hours of prescription. Otherwise, it is either taken from stock or obtained from a local pharmacy. The responsible physician determines the prescriptive practices at this facility. Medications are prescribed only when clinically indicated. Detainees entering the facility on prescription medication continue to receive the medication or an acceptable alternate medication as clinically indicated. The formulary includes a listing of medications detainees may keep on their persons, which include those with a low abuse potential. The detainee must also be reliable about taking their medications as prescribed. Tuberculosis, HIV, and psychotropic medications are exempt from the policy. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes: a medication room, five examination rooms, office space for providers, an emergency room, a one-chair dental operatory, a lab area, a conference room, medical records space, a waiting area, eight offices, a pharmacy, an x-ray suite, a nursing station, four negative pressure rooms, and two intake/exam rooms. Inventories are maintained on each shift for items subject to abuse. We verified the accuracy of the counts, and confirmed that adequate supplies and equipment, including three automated external defibrillators, were available. The standard is met.

J-D-04 Diagnostic Services (I). On-site diagnostic services include stool blood-testing material, finger-stick blood glucose tests, peak flow meters, multiple-test dipstick urinalysis, and pregnancy tests. X-rays are provided on site, and an off-site laboratory had been contracted to process specimens. We confirmed that lab and x-ray procedures manuals. The CLIA waiver was due to expire on November 29, 2018. The standard is met.

J-D-05 Hospital and Specialty Care (E). Hospitalization and specialty care is available to patients in need of these services. We verified through record review that off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions. At the time of the survey, there were no on-site specialty services. The standard is met.

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E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). Detainees receive verbal and written instruction in English and Spanish on access to health services, and the health-related grievance procedures. The appropriate accommodations are made for those who speak other languages or who have a hearing impairment. We observed an access-to-care sign had been posted in the intake area. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community. Reception personnel identify those individuals in need of emergency care and refer them immediately to a hospital or mental health facility. Their subsequent admission to the facility is predicated on a written medical clearance.

Qualified nurses complete the receiving screening, which includes a disposition and addresses the required areas of inquiry, immediately upon detainees' arrival. An RN reviews the screenings completed by an LPN. If a woman reports current opiate use, she is referred immediately for a pregnancy test. All pregnant women who are using opiates are immediately referred to the hospital. Prescribed medications are reviewed and maintained as clinically indicated. Health staff regularly monitors receiving screenings to determine the safety and effectiveness of the process. The standard is met.

J-E-03 Transfer Screening (E). A transfer screening is performed by qualified health care on all intrasystem transfers, immediately upon arrival at the facility. This consists of a record review and a face-to-face encounter. Medications, any necessary care, and referrals are provided. The review is documented in the electronic medical record. The standard is met.

J-E-04 Initial Health Assessment (E). The full population health assessment has been implemented at this facility. All detainees receive an initial health assessment by a physician or mid-level provider no later than 14 calendar days after admission. We confirmed the assessment consists of the required elements, including a review of the receiving screening results, and laboratory or diagnostic tests for communicable diseases. TB skin tests are performed on all detainees as well. The treating clinician reviews all the positive findings. Specific problems are integrated into an initial problem list, and diagnostic and therapeutic plans for each problem are developed as clinically indicated. The standard is met.

J-E-05 Mental Health Screening and Evaluation (E). A trained RN completes the mental health screening during intake. We confirmed that it includes the required areas of inquiry. Patients with positive results are referred to qualified mental health professionals for further evaluation.

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Mental health professionals review all intakes. If the detainee's mental health needs cannot be met at the facility, they are immediately transferred to a mental health facility for treatment. The standard is met.

J-E-06 Oral Care (E). Mid-level providers or physicians complete the oral screening at the health assessment. We verified that they had been trained to do so. Detainees are also instructed in oral hygiene and preventive oral education during intake, and we confirmed the dentist completes an oral examination within 12 months of their admission. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment was not limited to extractions. An oral surgeon is available for referrals and emergency treatment. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). All inmates, regardless of housing assignment, have access to regularly scheduled times for routine health care. The frequency and duration of response to requests for health services is sufficient for the inmate population. Detainees can sign up for sick call, or they can deposit a request into the unit mailbox. Nurses retrieve the slips daily and triages all requests. Urgent/emergent needs are seen right away, and other are scheduled to be seen later the same day. Patients can also request to be seen for urgent/emergent needs by requesting that the officer call health services, or the detainees can walk into health services at any time. Detainees are scheduled to see a provider as necessary, usually the next business day, or immediately if appropriate. The standard is met.

J-E-08 Emergency Services (E). The RHA maintains emergency drugs, supplies, and medical equipment, which is checked each shift. Detainees can be transferred to the hospital by a facility vehicle or an ambulance. The emergency facility is five minutes away. We also verified that emergency on-call services were available. The standard is met.

J-E-09 Segregated Inmates (I). The segregation unit consisted of 24 cells for men, and eight for women. Detainees are first brought to health services for a face-to-face assessment for possible contraindications or special accommodations.

Conditions of segregation at this facility meet NCCHC's category b, which required health rounds at least three times a week. In practice health staff conducts daily rounds, and mental health staff does so weekly. We confirmed the rounds are documented on a door care, in a logbook, and in the health record. Health staff informs custody officials of the latest scientific information concerning the health effects of segregation during the administrative meetings. The standard is met.

J-E-10 Patient Escort (I). Patients are escorted to on-site and off-site clinical appointments in a timely manner. Transporting officers are alerted to special accommodations, such as medication administration. The patient's confidentiality is maintained. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols are utilized at this facility. They do not include prescription medications, except epinephrine in an emergency, and a subsequent provider's order is obtained. The responsible physician and nursing administrator last reviewed them on November 6, 2017. We confirmed the nurses are trained to use the protocols upon hire and when they are introduced or revised. We also confirmed they undergo

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annual reviews of competency. They are also the subject of CQI process studies to determine if they are being used appropriately. The standard is met.

J-E-12 Continuity and Coordination of Care During Incarceration (E). We confirmed that continuity of care is appropriate. Clinician orders are evidence-based and implemented in a timely manner. Deviations are clinically justified, documented and shared with the patient. The clinician review diagnostic tests in a timely manner, and acts upon them appropriately. Treatment plans are modified as clinically indicated.

Patients receive treatment and diagnostic tests ordered by clinicians, who discuss such care with them. When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard. The clinicians review and act upon specialty consultants' recommendations in a timely manner.

The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations (Bureau of Prisons). Chart reviews were of sufficient frequency and number to assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is met.

J-E-13 Discharge Planning (E). The nursing staff and HSA are involved in discharge planning. They arrange follow-up appointments as indicated. All detainees leave with a discharge summary, a 30-day supply of medication, and a list of referral sources. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). The RHA utilizes the National Health Education Manual for detainee health education, and we confirmed that a variety of health-related brochures and pamphlets was available. Individual health education and instruction in self-care is documented in the health record during clinical encounters. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 96 medical diets were being prepared for patients with specific dietary needs. Detainees who refuse prescribed diets receive follow up nutritional counseling. Workers who prepare medical diets are trained and supervised.

However, a registered dietitian reviews the medical diet menus annually instead of every six months. The most recent review occurred on April 13, 2017. **The standard is not met.**

Corrective action is required for Compliance Indicator #2. (b)(5)

(b)(5)

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(b)(5)

J-F-03 Use of Tobacco (I). Smoking is prohibited at this facility. We confirmed that literature on the hazards of tobacco use was available to the detainees. The standard is met.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appears in compliance with current community standards. The responsible physician establishes and annually approves clinical protocols, consistent with national clinical practice guidelines (most recently in March 2018). We verified that there were guidelines for all nine disease entities. We verified the guidelines are used.

The treatment plans include all the appropriate elements: frequency of follow-up; monitoring condition, and status and taking action as indicated; type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medication and adaptation to correctional environment; and clinical justification of deviation from the protocols. Chronic illnesses were listed on the problem list, and we verified the RHA maintains a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health condition(s) of the patient, multi-disciplinary treatment plans define the individual's care, and include the frequency of follow-up, type and frequency of diagnostic testing and therapeutic regimens and instructions about diet, exercise, medication, and adaptation to the correctional environment. We confirmed that special needs were listed on the problem list, and that the RHA maintains a list of special needs patients. The standard is met.

J-G-03 Infirmary Care (E). There was no infirmary at the time of the survey. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Patients with mental health needs are either followed by the psychiatrist, if they are on psychotropic medication, or mental health workers, if not. The psychiatrist sees them at least every 30 days, or as clinically indicated. When clinically appropriate, a patient's commitment or transfer to an inpatient psychiatric setting is timely and accomplished according to procedures. Health services are integrated for patient management and to ensure patients' medical and mental health needs are met.

Basic on-site outpatient services include the identification and referral of inmates with mental health needs, crisis intervention services, psychotropic medication management when indicated, individual counseling, group counseling, psychosocial/psychoeducational programs, and treatment documentation and follow-up. The standard is met.

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J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence, and patient follow-up occurs as clinically indicated. Acutely suicidal inmates are placed on constant observation in a "safe cell," until they can be transferred to a mental health facility. The officer sits right outside the room with the door open. The non-acutely suicidal detainees are checked on a staggered schedule that does not exceed 15 minutes.

Mental health staff must see the detainee within 24 hours when they are placed on suicide precautions, and only they can discontinue suicide precautions.

There have been no suicides at this facility since the last survey. If there were an attempt, the patient would be sent to a mental health hospital for a more therapeutic milieu. The standard is met.

J-G-06 Patients with Alcohol And Other Drug Problems (AOD) (E). Disorders associated with AOD, such as HIV and liver disease, are recognized and treated. Correctional staff is trained to recognize detainees' AOD problems. Medical, mental health, and substance abuse staff communicate and coordinate with each other regarding patients' AOD care. Self-help substance abuse programs, individual counseling and group therapy are offered on site. The standard is met.

J-G-07 Intoxication and Withdrawal (E). Detoxification and withdrawal are provided at this facility. The nurses utilize protocols and a screening tool to assess the detainees. Any detainee requiring detoxification or experiencing withdrawal would be sent to the hospital for care, if indicated, and returned to the facility only when stable.

The facility's policy addresses the management of inmates, including pregnant inmates, on methadone or similar substances. If a pregnant inmate is admitted with opioid dependence, she is transferred to the hospital for assessment and treatment. The standard is met.

J-G-08 Contraception (I). Emergency and continuing contraception are available and can be obtained from the pharmacy. We confirmed that written information about contraception methods and community resources was available. The standard is met.

J-G-09 Counseling And Care Of The Pregnant Inmate (E). Pregnant detainees are housed at this facility. Counseling and assistance are provided in accordance to the detainee's wishes. Counseling is provided during the health assessment, which is completed the next business day after a detainee's arrival. Pregnant patients would then be transferred to a facility that has the necessary obstetrical services available. The standard is met.

J-G-10 Aids to Impairment (I). We observed detainees using wheelchairs, canes, hearing aids, and other devices during the tour. Health records documentation indicated that aids are provided as necessary. Nothing had been contraindicated for reasons of security. The standard is met.

J-G-11 Care for the Terminally Ill (I). Although it would be rare for a terminally ill patient to be held at this facility, procedures were in place to make the appropriate accommodations

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(discharge or transfer to another facility). There have been no such patients since the facility opened. Policies and procedures direct staff on caring for these detainees. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Inmates' medical and mental health records are integrated into the electronic medical record, which is available to all health staff. We confirmed that all the essential elements of a medical record were present. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are password-protected. Back-up records are locked in cabinets in the medical records room. Health staff have documented instruction in maintaining patient confidentiality during orientation and annually thereafter. If non-health staff transports health records, the records are sealed in an envelope. Custody staff also receives annual confidentiality training, and sign a confidentiality statement. The standard is met.

J-H-03 Management of Health Records (I). The electronic health record is available for each patient care encounter. When an inmate is transferred to another facility, copies of the current health record or a comprehensive health summary accompany him/her. The system maintains all medical records indefinitely. We verified they can be re-activated when the detainee re-enters the system. The standard is met.

J-H-04 Access to Custody Information (I). Qualified health care professionals have access to information in the inmate's custody record when such information may be relevant to the inmate's health and course of treatment. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). Clinical restraint and seclusion are not used at this facility, nor are custody-ordered restraints. Anyone requiring restraints would not be sent to this facility. The policy and procedure was appropriate. The standard is met.

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J-I-02 Emergency Psychotropic Medication (E). Such intervention would not be implemented at this facility; rather, the detainee would be transferred to a mental health facility. There has been no such instances since the facility opened. The policy and procedure were appropriate. The standard is met.

J-I-03 Forensic Information (I). Health staff does not collect forensic information; rather, the detainee is transferred off-site. The standard is met.

J-I-04 End-of-life Decision Making (I). Patients approaching the end of life are permitted to execute advance directives, if they terminal and have less than one year to live. Patients would be counseled as to the meaning and consequences of such actions, which would be documented in the health record, and the deputy director of clinical services would review them. In practice, such patients would be discharged or transferred. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). All informed consents and refusals of care are documented and consist of the required elements, including the signatures of the patient and a health staff witness. Patients are counseled as to possible adverse consequences to health that may occur as a result of a refusal. If the inmate refuses to sign a refusal form, two staff members, one of whom must be from health staff, would document it. The standard is met.

J-I-06 Medical and Other **Research (I).** Medical research does not occur at this facility. The standard is met.

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National Commission on Correctional Health Care

ACCREDITATION UPDATE REPORT OF

THE HEALTH CARE SERVICES AT

SOUTH TEXAS DETENTION COMPLEX

Pearsall, TX

February 20, 2019

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

AMERICAN OVERSIGHT

South Texas Detention Complex
February 20, 2019
UPDATE REPORT

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On February 26-27, 2018 NCCHC conducted its review for continuing accreditation of the South Texas Detention Complex under the NCCHC *2014 Standards for Health Services in Jails*. On April 22, 2018, NCCHC granted continuing accreditation with verification. Subsequently, the RHA has submitted corrective action, which brought the facility into compliance with applicable essential and important standards. Further corrective action brought the facility into full compliance. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's reports of April 22, and November 2, 2018.

There are 40 essential standards; 39 are applicable to this facility and 39 (100%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. **The South Texas Detention Complex has now met this condition.**

Essential Standards Not in Compliance
None

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. **The South Texas Detention Complex has met this condition.**

Important Standards Not in Compliance
None

Important Standard Not Applicable
J-G-08 Health Care Liaison

Decision: On February 20, 2019, the Accreditation Committee granted accreditation to the South Texas Detention Complex.

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the revised (effective January 2019) policy and procedure that emphasizes this. A CQI study on nine patients on suicide precautions (spanning November 29 through December 29, 2019) found that of the nine patients identified, eight were considered as non-acutely suicidal. All nine were placed on constant observation, and all met or exceeded the suicide observation standard: Eight of nine exceeded the requirements for non-acute monitoring, and one met the requirements for acute observation. Of the 10 days of continuous watch, nine days were documented as within 15 minutes, while one day's documentation occasionally fell outside. Overall compliance had improved to 90%.

The RHA also indicated monitoring for compliance would continue. **The standard is now met.**

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
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February 21, 2019

(b)(6); (b)(7)(C) MD
500 12th St. SW 2nd Floor
Washington, DC 20536

Dear (b)(6); (b)(7)(C)

Congratulations! The National Commission on Correctional Health Care (NCCHC), upon receipt of further documentation, determined that it will continue to accredit South Texas Detention Complex for its compliance with NCCHC's *Standards for Health Services in Jails.* Please find the accreditation report and Certificate of Accreditation enclosed. Your health services administrator will also receive a copy of the accreditation report.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime before February 1, 2021. If we can be of assistance to you, please feel free to call us at any time.

Sincerely,

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RN, CCHP-RN
Vice President, Accreditation

Enclosure

cc: (b)(6); (b)(7)(C) MHA, CHE, Chief Executive Officer

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National Commission on Correctional Health Care

Certificate of Accreditation

South Texas Detention Complex
Pearsall, Texas

The above-named facility is hereby recognized by the National Commission on Correctional Health Care, upon recommendation of its Accreditation and Standards Committee, to have met all the requirements of accreditation under NCCHC's *Standards for Health Services*.

February 20, 2019

ACCREDITED ★ NCCHC ★ QUALITY IN HEALTH CARE

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) PhD, CCHP-MH
Chair, NCCHC Board of Directors

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) MHA, CAE, CCHP
CEO, NCCHC

AMERICAN OVERSIGHT

Otay Mesa Detention Facility, CA
May 9, 2018
UPDATE REPORT

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On June 14-16, 2017 NCCHC conducted its review for continuing accreditation of the Otay Mesa Detention Facility under the NCCHC *2014 Standards for Health Services in Jails.* On September 22, 2017, NCCHC granted continuing accreditation with verification. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's September 22, 2017 report.

There are 40 essential standards; 39 are applicable to this facility and 38 (97%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. ***The Otay Mesa Detention Facility has not met this condition.***

Essential Standard Not in Compliance
J-G-01 Chronic Disease Services

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. **The Otay Mesa Detention Facility has met this condition.**

Important Standards Not in Compliance
None

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: On May 9, 2018, NCCHC's Accreditation Committee voted to continue the facility's Continuing Accreditation with Verification (CAV) status, contingent upon receiving requested compliance verification by July 9, 2018.

AMERICAN OVERSIGHT

J-G-01 Chronic Disease Services (E). Chronic illnesses are listed on the problem list, and the RHA maintains a list of chronic care patients. The responsible physician establishes and annually approves clinical protocols consistent with national clinical practice guidelines. We confirmed there were guidelines for all nine disease entities.

However, the RHA uses Medical Practice Guidelines, dated 2012. We noted that new guidelines have been developed, although there was no documentation of the date that they were implemented. The providers were unaware that they existed, and there was no documentation of any training for them, nor was there documentation to confirm the guidelines are followed.

The treatment plans do not include all the appropriate elements; frequency of follow-up, monitoring condition, and status and taking action as indicated, type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medication and adaptation to correctional environment, and clinical justification of deviation from the protocols. The standard is not met.

Corrective action is required for Compliance Indicator #1. (b)(5)

(b)(5)

Corrective action is required for Compliance Indicator #2. (b)(5)

(b)(5)

In February 2018, the RHA submitted the results of a CQI study of eight chronic care records (representing the most common conditions from February 14-22, 2018). The records were reviewed for the following criteria: 1) provider determined frequency of follow-up based on disease control; 2) provider noted condition and status; 3) appropriate action taken to improve outcome; 4) provider indicated type and frequency of diagnostic testing and therapeutic regiments (e.g., diet, medication, exercise); 5) documented instruction on diet, exercise, adaptation to correctional environment and/or medication; and 6) documented clinical deviation from protocol. A threshold

AMERICAN OVERSIGHT

of 87% was selected. Compliance was demonstrated at 100% in all applicable cases for the first five criteria (the sixth was not applicable in this study).

The RHA also submitted a list of guidelines based on national guidelines (such as the Federal Bureau of Prisons), and evidence of provider training in February 2018.

Further corrective action is required regarding compliance with the protocols: (b)(5)
(b)(5)
(b)(5) **The standard is not met.**

AMERICAN OVERSIGHT

National Commission on Correctional Health Care

To Whom It May Concern:

NCCHC's Accreditation Committee has requested further verification of compliance with one or more standards in the enclosed report. Please take a moment to review the guidelines below for submitting corrective action to NCCHC. Following these guidelines will expedite the processing and review of the documentation. Please allow 60 to 90 days after submission for an update report to be returned to the facility. The accreditation staff are available to answer any questions you may have after reviewing the report and the corrective action requirements. We can be reached at 773-880-1460.

Submission of Corrective Action Guidelines

- **All documentation must be scanned and submitted on a thumb drive or a CD**
- Please organize and clearly label materials by the standard it is intended to address
- Documents should be in Word or PDF format and files should not be "zipped"
- **Please be sure to highlight relevant portions of documents: revisions to policies and procedures, screening/assessment forms, etc.**
- Clearly identify the *name of your facility* on the submission, rather than noting only a state name, corporate vendor, or system headquarters
- If we have not received corrective action by the noted deadline, NCCHC will contact the facility HSA
- Review your submission to ensure it is complete and addresses all standards with compliance issues
- Please send only the information that is requested (e.g., if corrective action requires specific protocols for G-01, send only the requested protocols and not others that may not be required by the standard)
- Remember, evidence of practice is key and implementation of a plan, study results, and other clear documentation of compliance is what NCCHC looks for to assess whether a standard is met
- We recommend that you send materials via FedEx, UPS, or another reliable delivery service that can be tracked
- **Due to the volume of incoming materials, we ask that you verify receipt through your delivery service rather than contact NCCHC**

Please submit the thumb drive or CD to:

National Commission on Correctional Health Care
ATTN: Accreditation Department
1145 W. Diversey Parkway
Chicago, IL 60614

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National Commission on Correctional Health Care

ACCREDITATION REPORT OF

THE HEALTH CARE SERVICES AT

STEWART DETENTION CENTER

Lumpkin, GA

April 22, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

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Stewart Detention Center, GA
April 22, 2018

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On January 29-30, 2018, NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2014 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 40 essential standards; 38 are applicable to this facility and 33 (87%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance
J-A-07 Emergency Response Plan
J-E-01 Information on Health Services
J-E-02 Receiving Screening
J-E-05 Mental Health Screening and Evaluation
J-G-05 Suicide Prevention Program

Essential Standards Not Applicable
J-G-03 Infirmary Care
J-G-09 Counseling and Care Of The Pregnant Inmate

There are 27 important standards; 25 are applicable to this facility and 25 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance
None

Important Standards Not Applicable
J-C-08 Health Care Liaison
J-G-08 Contraception

Decision: On April 22, 2018, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by August 22, 2018.

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Stewart Detention Center, GA
April 22, 2018

I. Facility Profile

The facility's security classification is: Medium
The facility was built in: 1999
The facility's mission or purpose has not changed since the last survey.
The facility is located in the southeastern United States.
The facility's supervision style is: Direct Supervision.
The facility's structural layout is: Dormitory-Style Housing.
Since the last NCCHC survey medical expanded into the former ICE office space.
There is a major renovation in progress of the medical clinic.
Total Inmate Count on day of survey: 1884
Total number of adult males on day of the survey: 1884
Average Daily Population (ADP) for last completed calendar year: 1826
The design-rated capacity for the facility is: 2042
There has not been a substantial increase in the inmate population.
Admissions to the facility arrive on a scheduled basis.
The total number of admissions to the facility last year was: 11794
The average daily intake to the facility last year was: 45
The total number of correctional staff assigned to this facility is: (b)(7)(E)
The usual shift coverage for correctional staff is: (b)(7)(E)
There has not been a recent change in health care contractor.
Health services are provided by United States Public Health Services.
They have provided health services since: 2006
There have not been distinctive events that may affect the delivery of health care.
The facility has no satellites.

II. Survey Method

We toured the clinic area, detainee housing areas, and segregation. We reviewed 25 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the warden, assistant warden, safety officer, chief of security, facility training officer, responsible physician, health services administrator (HSA), other health, dental, and mental health staff, medical records clerk, 13 COs, and nine detainees selected at random.

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Stewart Detention Center, GA
April 22, 2018

III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Detainees have access to health care. Patients see a qualified clinician and receive care for their serious medical, mental health, and dental needs. There was no fee-for-service policy at the time of the survey. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is the United States Public Health Services (USPHS), the on-site representative is the full-time health services administrator (HSA). Clinical judgments rest with a designated, full-time, responsible physician. The designated mental health clinician is also a full-time employee. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding detainees' serious medical, dental, and mental health needs in the detainees' best interests. We noted good cooperation between custody and medical staff. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. Health staff is subject to the same security regulations as other facility employees. The standard is met.

J-A-04 Administrative Meetings and Reports (E). The warden meets weekly with all the stake holders to discuss administrative and health-related matters. Membership includes the warden, assistant warden, chiefs of security and housing, assistant field officer, deportation officer, a lawyer from the General Counsel's office, medical director, HSA, and mental health clinician.

Health staff meets monthly to discuss health services operations. Attendees include the health services leadership team, HSA and assistant HSA, mental health staff, medical director, nurse practitioners, physician assistants and nursing staff. Statistical reports of health services are collected monthly and provided to the members of the facility stake holders' meeting, medical staff and corporate office staff. The statistical report is used to monitor trends in the delivery of health care. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy manual is site-specific. The RHA, warden and responsible physician last reviewed it in December 2017. Other policies, such as those for custody, kitchen, or corporate, do not conflict with health care policies. The policies are accessible to health staff. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee

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consists of HSA, nurse practitioner, physician assistant, director of nursing, mental health clinician, medical director, assistant HSA, and nursing staff.

Three site-specific process studies have been completed since the last survey. The topics included: 1) correct identification of asthmatic patients during the screening process; 2) completion of blood sugar during intake screening of diabetic patients; and 3) proper documentation on the suicide log by nursing staff. All studies contained a clearly identified problem and a baseline study. All required a corrective action plan, and after staff retraining, 100% compliance was demonstrated upon re-evaluation.

The HSA reported active physician involvement in the CQI program, and we confirmed that the program has been reviewed annually for its effectiveness. The standard is met.

J-A-07 Emergency Response Plan (E). The RHA approved the health aspects of the facility's emergency response plan. Multiple casualty disaster drills have been held annually. The scenarios included: a riot on the recreation yard, a fight in the housing unit involving 80 detainees, and a tornado destroying a portion of the facility. These were all simulated events that involved community emergency response personnel. The drills had been critiqued and the results were shared with the health staff.

Man-down drills (simulated events) are held monthly on all three shifts. We confirmed that these have also been critiqued and the results are shared with all health staff.

However, the multiple casualty drills were only held on the day shift. **The standard is not met.**

Corrective action is required for Compliance Indicator #2. (b)(5)

(b)(5)

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health services staff with regards to detainees' special health needs occurs both in writing, verbally and electronically. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters and discussion of patient information is conducted in auditory and visual privacy. Security personnel are present only if the patient poses a risk to the safety of the health care professional or others. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there was one detainee death, which was a suicide. A death review was conducted within 30 days, and consisted of the required elements: administrative and clinical mortality reviews, and a psychological autopsy. We also confirmed that treating staff were informed of the findings. The standard is met.

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J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the formal grievance program. On average, ten health-related grievances are filed per month. The facility grievance monitor collects all grievances, assigns a tracking number, and forwards them to the correct department for resolution. The HSA has five days to answer. If a detainee is not satisfied with the grievance resolution, he may appeal. The grievance is returned to the HSA for reconsideration. If the grievance remains unresolved, it is forwarded to the facility grievance manager.

We reviewed the log the HSA maintains, and confirmed the responses are timely. The standard is met.

B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Prevention and Control Program (E). The responsible physician has approved the written exposure control plan, which is updated annually, most recently on January 23, 2018. Infection control matters are addressed at the weekly stakeholders' meeting, and CQI and health staff meetings. Patients with communicable diseases are housed in the negative airflow room on site. Effective ectoparasite control procedures are used to treat infected detainees. Health services areas are inspected monthly for environmental concerns. The standard is met.

J-B-02 Patient Safety (I). Patient safety systems were in place to prevent adverse and near-miss clinical events, which staff can report in a non-punitive environment. All incidents that could affect a patient's safety are examined to determine the cause, and that information is shared with the staff. The standard is met.

J-B-03 Staff Safety (I). Health staff appears to work under safe and sanitary conditions. Appropriate personal protective equipment, biohazard containers and supplies were on hand. Workplace safety systems included security presence in the medical clinic area, a camera system to monitor staff and detainee movement, and security escorts for medical staff during medication administration rounds. The standard is met.

J-B-04 Federal Sexual Abuse Regulations (E). Written policies and procedures address the detection, prevention and reduction of sexual abuse. The warden described the facility as compliant with the 2003 Federal Prison Rape Elimination Act (PREA). The facility's PREA audit was conducted September 19-20, 2017, and the facility was found to be in full compliance with PREA standards. We observed signs posted throughout the facility regarding the reporting of sexual offenses. Upon arrival, detainees are also given written instructions and watch a PREA video regarding reporting procedures. The standard is met.

J-B-05 Response to Sexual Abuse (I). All health staff had been trained in how to detect, assess, and respond to signs of sexual abuse and sexual harassment, as well as how to preserve physical evidence. Training is part of orientation, and reviewed annually thereafter. All

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detainees undergo a PREA screening upon arrival to assess their risk of victimization. All victims of sexual assault are referred to the local emergency room for treatment and evidence collection. Victims of sexual assault are evaluated by a qualified mental health professional and a report is made to correctional authorities for housing separation of the victim from the assailant. The standard is met.

C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentials (E). Health care personnel who provide services to detainees had credentials and were providing services consistent with the jurisdiction's licensure, certification, and registration requirements. The administrative assistant is responsible for the credentialing process for local hires, and maintains the original file. The staff at the national personnel office is responsible for the credentialing process for the USPHS personnel. We reviewed copies of licenses and certificates on site, including a copy of the National Practitioner Data Bank query. The standard is met.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed written documentation listing the names of the individuals being reviewed and the date of their most recent review, and confirmed that provider staff had a documented review completed. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals had the required number of continuing education credits. State licensure requires continuing education in order to maintain a clinical license to practice. We reviewed a list of completed courses, dates, and number of hours per course to confirm compliance. We also verified that all staff were current in cardiopulmonary resuscitation (CPR) training. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff had the required training in health-related topics, and all were current in their health-related training. The facility training officer tracks all requirements electronically. We reviewed sign-in rosters and the training outline including course content and length, which included the required topics. The standard is met.

J-C-05 Medication Administration Training (E). Registered nurses and licensed practical nurses administers medications. Medication administration training is addressed during orientation, and annually during competency assessments. We verified that it includes matters of security, accountability, common side effects, and documentation, that completion is documented appropriately, and that the facility administrator and RHA have approved the curriculum. The standard is met.

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J-C-06 Inmate Workers (E). Detainee workers are trained by the safety officer on personal safety, infection control and blood borne pathogens topics, and they are supervised by security staff to perform basic janitorial services as laundry and food service workers. They do not handle biohazardous materials or clean such spills, or provide health services. Their training was appropriately documented. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

(b)(7)(E)

At the time of the survey the following health staff positions were vacant:

(b)(7)(E)

The standard is met.

J-C-08 Health Care Liaison (I). Health staff is on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff had received the appropriate orientation, which was documented electronically. We also verified that the RHA and facility administrator have approved it at least every two years. The standard is met.

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D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). An on-site pharmacy, staffed by (b)(7)(E) (b)(7)(E) provides pharmaceutical services that are sufficient to meet the needs of the detainees. Medication are ordered from a national company, or a local pharmacy as back-up. Pharmacy technicians deliver keep-on-person (KOP) medications to the detainees and stock the medication cart as needed. Medications administered by nursing staff come from stock supply. While there was a formulary, we confirmed that clinicians may order non-formulary medications if necessary.

We also confirmed that medications were under the control of appropriate heath care staff and stored under appropriate conditions. The RHA maintain records as necessary to ensure adequate control of, and accountability for, controlled medications. Stock medication is inventoried weekly, although at the time of the survey, the pharmacist was developing another system to track usage. The medication room was clean, uncluttered and secure, and controlled substances were properly monitored. The number for the poison control center was accessible in the clinic. Discontinued medications, or outdated medications are retrieved for destruction via a reverse distribution contract. We confirmed there was an adequate supply of antidotes and other emergency medications, and that the on-site pharmacist inspects the pharmacy monthly, most recently in January 2018. The standard is met

J-D-02 Medication Services (E). Medication services were clinically appropriate and provided in a timely, safe and sufficient manner. Once ordered, they are usually delivered during the next medication pass, usually within 24 hours. Medications are delivered to the detainee housing area four times a day. If a medication is not available within 24 hours, there was a back-up plan to ensure timely administration. The responsible physician determines the prescriptive practices at the facility. Detainees entering the facility on prescription medication continue to receive the medication as prescribed. Medications are prescribed only when clinically indicated. A keep-on-person (KOP) self-medication program was in place at the time of the survey. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes a waiting area, five examination rooms, nursing office space, two dental operatories, two mental health offices, two mental health examination rooms, a radiology room, a laboratory, and two medical housing rooms both of which were negative pressure rooms. Items subject to abuse are inventoried daily. We verified the accuracy of sharps and narcotics counts, and confirmed that adequate supplies and equipment were available, including two automated external defibrillators. The standard is met.

J-D-04 Diagnostic Services (I). On-site diagnostic services include stool blood-testing material, finger-stick blood glucose tests, peak flow meters, multiple-test dipstick urinalysis, electrocardiograms and chest x-rays. More complex studies are completed at the local hospital. Dental x-rays are also taken on site. A contracted provider supplies laboratory services. A

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Clinical Laboratory Improvement Amendment (CLIA) wavier with an expiration date of November 17, 2018 was on file. Diagnostic procedure manuals were available, and included the protocols for testing device calibration. The standard is met.

J-D-05 Hospital and Specialty Care (E). Hospitalization and specialty care is available to patients in need of these services. We verified through record review that off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions. If summaries are not returned with the patient, a release of information form is sent to the local hospital to request it. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). During receiving, detainees receive verbal and written instructions (in English and Spanish) on access to health care services and the health-related grievance procedures. A licensed clinical social worker sees hearing-impaired/deaf, developmentally disabled, illiterate, and mentally ill detainees to develop a plan of care. Those who speak other languages can use the language conversion system (Interpret Talk) to communicate.

However, there was no access to care sign posted in the intake area. **The standard is not met.**

Corrective action is required for Compliance Indicator #1. (b)(5)

(b)(5)

J-E-02 Receiving Screening (E). New admissions seldom arrive directly from the community. Medical staff complete a pre-screening to identify those individuals in need of care and refer them immediately to the local hospital. Their subsequent admission to the facility is predicated on a written medical clearance from the hospital.

After the pre-screening, the intake screening is conducted which consists of the required areas of inquiry and includes a disposition. Prescribed medications are verified and maintained as clinically indicated. The HSA and the assistant HSA monitors the receiving screenings daily to determine the safety and effectiveness of the process.

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While medical staff completes a receiving screening on all detainees entering the facility, this does not take place until eight to ten hours after arrival. **The standard is not met**.

Corrective action is required for Compliance Indicator #5 (b)(5)

(b)(5)

J-E-03 Transfer Screening (E). Qualified health care professionals review each transferred detainee's health record or summary to ensure continuity of care. Receiving screening is completed for all incoming detainees. The standard is met.

J-E-04 Initial Health Assessment (E). The full population health assessment has been implemented at this facility. A nurse practitioner or physician assistant completes the health assessment on detainees identified with a chronic condition or health concern within 48 hours. A trained RN completes a health assessment on detainees with no identified health concerns within 14 days. We verified that the health assessment consists of the required elements, including a review of the receiving screening. Specific problems are integrated into an initial problem list, diagnostic and therapeutic plans for each problem are developed as clinically indicated, and immunizations are offered as needed. The standard is met.

J-E-05 Mental Health Screening and Evaluation (E). Trained medical staff completes the mental health screening. Patients who screen positive on the mental health screening are referred to qualified mental health professionals for further evaluation.

However, the screening does not address the following required areas of inquiry: substance use hospitalization, detoxification, outpatient treatment and cerebral trauma or seizures. **The standard is not met.**

Corrective action is required for Compliance Indicators # 2a-d (b)(5)

(b)(5)

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revised initial mental health screening form including all of the noted elements, with evidence of its implementation. In order to receive accreditation, verification that this standard has been met is required.

J-E-06 Oral Care (E). A trained RN completes the oral screening during the receiving screening. Detainees are instructed in oral hygiene and preventive oral education during the intake process. The dentist completes an oral examination within 12 months of detainees' admission. The oral care is timely and includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). All detainees, regardless of housing assignment, have access to regularly scheduled times for routine health care. Security staff announces sick call, and escort any detainee desiring to see a provider to the clinic. All requests for health services are completed by a provider in a face-to-face encounter. The standard is met.

J-E-08 Emergency Services (E). The RHA provides 24-hour emergency medical, mental health, and dental services, and maintains emergency drugs, supplies, and medical equipment. We verified that emergency on-call services were also available. Detainees are transported to the local emergency treatment facility by emergency medical services. The standard is met.

J-E-09 Segregated Inmates (I). Conditions of segregation at this facility (NCCHC's category 2b) require health rounds at least three times a week, and once a week by mental health staff. In practice, health staff rounds are completed daily, and mental health rounds are completed weekly. We confirmed these rounds are documented appropriately, and significant findings noted in the health record.

Upon notification that a detainee is to be segregated, a qualified health care professional assesses the detainee, and reviews his health record to determine whether there are any contraindications for segregation. Health staff promptly identifies and inform custody officials when detainees are physically/psychologically deteriorating, or are exhibiting other signs of failing health. They also inform custody officials of the latest scientific information concerning the health effects of segregation during the weekly segregation meeting. The standard is met.

J-E-10 Patient Escort (I). Patients are escorted to on-site and off-site clinical appointments in a timely manner. Transporting officers are alerted to special accommodations that are necessary during transport. Appropriate steps are taken to ensure patient confidentially, such as carrying medical information in sealed envelopes. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols are utilized, and do not include prescription medications. We verified that nurses are trained to use the protocols upon hire, when they are revised and annually during competency review. The protocols were last reviewed January 30, 2018. The standard is met.

J-E-12 Continuity and Coordination of Care During Incarceration (E). We confirmed that continuity of care is appropriate. Clinician orders are evidence-based and implemented in a timely manner. Deviations are clinically justified, documented and shared with the patient. The

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clinician reviews diagnostic tests in a timely manner, and modified treatment plans as clinically indicated.

When a patient returns from the emergency room, urgent care or hospitalization, he sees a provider to ensure discharge orders are implemented and appropriate follow-up completed. Specialty consultants' recommendations are reviewed and acted upon in a timely manner. Changes in treatment are shared with the patient. Treatment protocols are followed in accordance with the standard.

The responsible physician determines the frequency of periodic health assessments. The medical director reviews all detainee medical records to assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is met.

J-E-13 Discharge Planning (E). Discharge planning is coordinated between medical, ICE and embassy personnel. Every attempt is made to determine the availability of health care in other countries for detainees being repatriated. Repatriated individuals receive a 30-day supply of medication upon deportation. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). A variety of health-related information is available to all detainees. Detainees are instructed on health care access, oral hygiene, healthy life styles, personal hygiene, the risks of smoking and tobacco use, safe medication usage, and mental health issues as part of the receiving screening. We verified that individual health education and instructions in self-care is documented in the health record during clinical encounters. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 299 medical diets were being prepared for patients with specific dietary needs. Detainees who refuse prescribed diets receive follow up nutritional counseling. A registered dietitian reviews the medical diet menus at least every six months, most recently on September 25, 2017. Workers who prepare medical diets are supervised by food service personnel while doing so. The standard is met.

J-F-03 Use of Tobacco (I). Smoking is prohibited indoors. Information on the health hazards of tobacco is given to all detainees during intake screening. The standard is met.

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G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appears in compliance with current community standards. The responsible physician establishes and annually approve clinical protocols consistent with national clinical practice guidelines. Clinical guidelines for all nine diseases were in place, including guidelines on sickle cell.

Health records documentation confirmed that clinicians follow the chronic disease protocols. Treatment plans include the appropriate elements (frequency of follow-up; monitoring condition and status and taking action as indicated; type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medications and adaptation to correctional environment; and clinical justification of deviation from the protocols). Chronic illnesses were listed on the problem list, and we confirmed the RHA maintain a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health conditions of the patient, treatment plans define the individual's care, and include the frequency of follow-up, type and frequency of diagnostic testing and therapeutic regimens, and instructions about diet, exercise, adaptation to the detention environment and medications. Special needs were listed on the problem list, and we confirmed the RHA maintains a list of special needs patients. The standard is met.

J-G-03 Infirmary Care (E). There was no infirmary at the time of the survey, although there were two medical housing cells in the clinic which were also negative pressure rooms. Infirmary-level patients would be transferred to the local hospital. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). On-site mental health services include a full range of which, to include the identification and referral of detainees with mental health needs, crisis intervention services, psychotropic medication management when indicated, individual and group counseling, psychosocial/psychoeducational programs, and treatment documentation and follow-up. When clinically appropriate, a patient's commitment or transfer to an inpatient psychiatric setting is timely and accomplished according to procedures. Outpatients receiving basic mental health services are seen at least every 90 days or as clinically indicated. Mental health and medical services are coordinated to facilitate integrated patient management and to ensure patients' medical and mental health needs are met. Special programs include crisis intervention, individual and group counseling. The standard is met.

J-G-05 Suicide Prevention Program (E). There has been one suicide at this facility since the last survey.

The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence, and patient follow-up occurs as clinically indicated. There are three levels of observation for suicidal patients. Patients on levels one and two are placed on

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constant observation in the segregated housing area where such observation can be maintained. Non-acutely suicidal detainees (level three) are housed in the same housing area, but they are not monitored on an unpredictable (staggered) schedule. We observed documentation is recorded is on a preprinted form describing precise, 15-minute intervals. **The standard is not met.**

Corrective action is required for Compliance Indicator #1d. (b)(5)

(b)(5)

J-G-06 Patients with Alcohol And Other Drug Problems (AOD) (E). Disorders associated with AOD, such as HIV and liver disease, are recognized and treated. Detention staff had been trained to recognize detainees' AOD problems. Medical and mental health communicates and coordinates with each other regarding patients' AOD care. Individual counseling and group therapy are offered on site. The standard is met.

J-G-07 Intoxication and Withdrawal (E). All detainees are screened for their degree of reliance on substances, and potential for withdrawal, upon arrival. Those who demonstrate acute symptoms of intoxication or withdrawal are transferred to the local hospital for treatment. The RHA had approved the protocols, which are consistent with nationally accepted treatment guidelines for intoxication and withdrawal. The Clinical Opiate Withdrawal Scale (COWS) and health vendor's assessment guidelines were last approved on March 24, 2017. The standard is met.

J-G-08 Contraception (I). The population at this facility is all male. The standard is not applicable.

J-G-09 Counseling And Care Of The Pregnant Inmate (E). The standard is not applicable.

J-G-10 Aids to Impairment (I). We observe detainees using crutches and wearing glasses during the tour. Health records documentation indicated aids are provided as necessary. All aids to impairment are approved by security if considered medically necessary. The standard is met.

J-G-11 Care for the Terminally Ill (I). Although it would be rare for a terminally ill patient to be held at this facility, procedures were in place to make the appropriate accommodations, such as arranging for advance directives, a compassionate release, or the patient's transfer to a hospital. At the time of the survey, one terminally ill detainee was being housed as an inpatient at the Mayo Clinic. The standard is met.

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H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Detainees' medical and mental health records are integrated in electronic format. The health record includes a problem list, as well as all other critical elements. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are password-protected, and are separate from correctional records. Instructions on maintaining patient confidentiality is provided during new employee orientation and is documented. When non-health staff transports health records, the records are secured in a sealed envelope to ensure patient confidentiality. The standard is met.

J-H-03 Management of Health Records (I). The health record is available for each patient care encounter. When a detainee is deported, a copy of the current health record or a comprehensive health summary accompanies him. The jurisdiction's legal requirements regarding records retention are followed. If detainees return to the system, their health record is reactivated and available during patient encounters. The standard is met.

J-H-04 Access to Custody Information (I). Qualified health care professionals have access to information in the detainee's detention record when such information may be relevant to the detainee's health and course of treatment. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). Clinical restraints, seclusion or custody-ordered restraints are not used at this facility. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). Although emergency psychotropic medication is not implemented at his facility, the policies require a licensed clinician's authorization for its use. The standard is met.

J-I-03 Forensic Information (I). Health staff does not collect forensic information at this facility. The standard is met.

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J-I-04 End-of-life Decision Making (I). By policy, detainees approaching the end of life are permitted to execute advances directives, after being counseled as to the meaning and consequences of such actions. In practice, terminally ill detainees would be transferred to an inpatient facility. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). We verified that all informed consents and refusals of care are documented in the health record and include the signatures of the patient and a health staff witness. Patients are counseled as to possible adverse consequences to their health that may occur as a result of a refusal. Should a patient refuse to sign the refusal of care form, a health staff member and a second person would sign as witnesses. The standard is met.

J-I-06 Medical and Other Research (I). No health-related research is conducted at this facility. The standard is met.

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

February 27, 2017

(b)(6); (b)(7)(C)
500 12th St. SW 2nd Floor
Washington, DC 20536

Dear (b)(6); (b)(7)(C)

The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC) met on February 24, 2017 to review the findings from a recent survey and to consider the accreditation status of El Paso Service Processing Center. The Committee voted to continue the accreditation of your facility with the following qualification: that compliance be demonstrated with all of the essential standards and at least 85% of the applicable important standards. Compliance should be documented in a report and submitted to NCCHC by June 23, 2017. Enclosed is the accreditation report for your facility, listing cited standards and recommendations for achieving compliance.

The Committee acknowledged the facility's significant level of compliance with a number of NCCHC standards. However, in order to maintain your accreditation, it is important that you address the cited standards in a timely manner.

Following receipt of documentation and verification of compliance, a Certificate of Accreditation will be sent to you indicating your facility's accreditation status. Please let us know if we can be of any assistance.

Sincerely,

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RN, CCHP-RN
Vice President, Accreditation

Enclosure

cc: (b)(6); (b)(7)(C) MD, CCHP, Chair

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ACCREDITATION REPORT OF

THE HEALTH CARE SERVICES AT

EL PASO SERVICE PROCESSING CENTER

El Paso, TX

February 24, 2017

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

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El Paso Service Processing Center, TX
February 24, 2017

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On December 7-9, 2016, NCCHC conducted its review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2014 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 40 essential standards; 38 are applicable to this facility and 36 (95%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance
J-E-06 Oral Care
J-E-12 Continuity and Coordination of Care

Essential Standards Not Applicable
J-E-03 Transfer Screening
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance
None

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: On February 24, 2017, NCCHC's Accreditation Committee awarded the facility Continuing Accreditation with Verification (CAV), *contingent* upon receiving requested compliance verification by June 23, 2017.

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El Paso Service Processing Center, TX
February 24, 2017

I. Facility Profile

The facility's security classification is: Multi-level (minimum, medium, and maximum).
The facility was built in: 1967
The facility's mission or purpose has not changed since their last survey.
The facility is located in the Southwestern United States.
The facility's supervision style is: Direct Supervision.
The facility's structural layout is: Linear-Style Housing
Since the last NCCHC survey, there have not been any major renovations/expansions/closures, although major renovations/expansions/closures were anticipated at the time of the survey: A double-wide, portable building has been brought on-site. A building was being constructed for additional health care offices. The current offices will be utilized for providing health care services. Their exact usage had not been decided, at the time of the survey.
Total Detainee Count on day of survey: 849
Total number of adult males on day of the survey: 634
Total number of adult females on day of the survey: 215
Total number of juvenile males on day of the survey: Facility doesn't house juveniles.
Total number of juvenile females on day of the survey: Facility doesn't house juveniles.
Average Daily Population (ADP) for last completed calendar year: 708
The design-rated capacity for the facility is: 870
There has not been a substantial increase or decrease in the detainee population.
Admissions to the facility arrive: unscheduled and at any time of day.
The total number of admissions to the facility last year was: 6,855.
The average daily intake to the facility last year was: 19.
The total number of correctional staff assigned to this facility is: (b)(7)(E)
The usual shift coverage for correctional staff is: (b)(7)(E)
There has not been a recent change in health care contractor.
Health services are provided by a federal agency.
They have provided health services since: 1989.
There have not been distinctive events that may affect the delivery of health care.
The facility has no satellites.

II. Survey Method

We toured the clinic area, detainee housing areas, intake area, food service, and segregation. We reviewed 14 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the warden, responsible physician, health services administrator (HSA), assistant health services administrator (AHSA), other health, mental health, and dental staff, the pharmacist, intake officer, food services supervisor, medical records clerk, four COs, and six detainees selected at random.

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El Paso Service Processing Center, TX
February 24, 2017

III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Detainees have access to health care. Patients see a qualified clinician and receive care for their serious medical, mental health, and dental needs. There was no fee-for-service program at the time of the survey. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is the federal agency, whose on-site representative is the full-time HSA. Clinical judgments rest with a designated, full-time responsible physician. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding detainees' serious medical, dental, and mental health needs in the detainees' best interests. We noted good cooperation between custody and medical staff. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. The health staff is subject to the same security regulations as other facility employees. The standard is met.

J-A-04 Administrative Meetings and Reports (E). The department heads and facility administrator meet monthly to discuss administrative matters with health staff and detention supervisors. Health staff meets monthly to discuss health services operations. Attendees include the responsible physician, HSA, the compliance officer, and mental health, pharmacy, dental, and nursing staff. The facility administrator receives monthly statistical reports of health services utilization, which are used to monitor trends in the delivery of health care. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy manual is site-specific. The RHA and responsible physician last reviewed it in October and November, 2016. Other policies such as those for custody, kitchen, or corporate do not conflict with health care policies. The policies are accessible to health staff. The standard is met.

J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee consists of the responsible physician, HSA, AHSA, nurse manager, compliance officer, mid-levels providers, and representatives from medical records, mental health, pharmacy, and dental. The committee identifies problems, establishes thresholds, designs monitoring activities, analyzes the results and remonitors performance after implementing improvement strategies. More than 45 site-specific process and outcome studies have been completed since the last survey. Recent studies examined mental health screening, reasonable accommodations, sick call, training, hypertension, diabetes, dental care, hunger strikes, and other aspects of care.

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Studies contained clearly identified problems, baseline studies, corrective action plans that had been implemented, and restudied to evaluate effectiveness. The established thresholds were also met.

The responsible physician involved in the CQI program. She attends the meetings, review charts, and helps determine trends and areas that should be studied. The CQI program is reviewed for its efficacy at the end of each year. The standard is met.

J-A-07 Emergency Response Plan (E). The RHA and facility administrator have approved the health aspects of the emergency response plan, which includes the required elements. Multiple casualty disaster drills have been held annually so that over the course of three years, staff on each shift has had an opportunity to participate. The scenarios included: a riot, a vehicular accident, and a warehouse explosion. Community agencies also participated. The drills have been critiqued and the results were shared with the health staff.

Man-down events have been documented and confirmed that health staff on each shift has been able to participate annually. These have also been critiqued and the results were shared with all health staff. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health services staff with regard to detainees' special health needs occurs in writing and electronically. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters and discussion of patient information are conducted in auditory and visual privacy. Security personnel are present only if the patient poses a probable risk to the safety of the health care professional or others. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there have been no detainee deaths. We verified that policy and procedure were in compliance with the standard. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is integrated with the facility's formal grievance program. Detainees may also informally discuss their concerns with a staff member before submitting a formal grievance. On average 10 health-related grievances are filed per quarter. Detainees may appeal to the warden and a committee, if necessary. We verified the responses have been timely. The standard is met.

B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Prevention and Control Program (E). The responsible physician has approved the written exposure control plan and is updated annually, most recently on January 26, 2016. Infection control matters are addressed at the monthly Safety Infection Prevention Committee, CQI, and staff meetings. Patients with communicable diseases are placed in one of

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the three on-site negative pressure rooms. Effective ectoparasite control procedures are used to treat infected detainees. The health services areas inspected monthly for environmental concerns. The standard is met.

J-B-02 Patient Safety (I). A written safety management plan has been implemented to prevent adverse and near-miss clinical events, which staff can report in a non-punitive environment. The standard is met.

J-B-03 Staff Safety (I). Health staff appears to work under safe and sanitary conditions. The standard is met.

J-B-04 Federal Sexual Abuse Regulations (E). The Warden described the facility as compliant with the 2003 Federal Prison Rape Elimination Act (PREA). Written policies and procedures address the detection, prevention and reduction of sexual abuse. The standard is met.

J-B-05 Response to Sexual Abuse (I). Health staff has been trained during orientation and annually thereafter in how to detect, assesses, and respond to signs of sexual abuse and sexual harassment, as well as how to preserve physical evidence of sexual abuse. Completion is documented electronically and in the personnel files. Victims of sexual assault are referred to a community facility for treatment and evidence collection. In all cases, the victim is evaluated by a qualified mental health professional, and a report is made to correctional authorities to effect a housing separation of the victim from the assailant. The standard is met.

C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentials (E). Health care personnel who provide services to detainees had credentials and were providing services consistent with the jurisdiction's licensure, certification, and registration requirements. The administrative assistant on site and representative of the health vendor are responsible for the monthly on-going credential verification process, which includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank. The standard is met.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a log listing the names of the individuals being reviewed and the date of their most recent review, which included required elements. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals had the required number of continuing education credits, All were current in cardiopulmonary

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resuscitation (CPR) training, as well. The state requires continuing education credits for license renewal. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff had the required training in health-related topics, and all were current in their health-related training. All officers have to participate annually. We reviewed the training outline, including course content and length, and confirmed it includes all the required topics. The standard is met.

J-C-05 Medication Administration Training (E). Nurses administer medications. They are trained during orientation and annually thereafter, and complete a post-test. The training, which the HSA and facility administrator have approved, includes matters of security, accountability, common side effects, and documentation. It is documented electronically and in the personnel files. The standard is met.

J-C-06 Inmate Workers (E). Detainee workers do not provide health services, nor are they involved in any peer health-related programs. They may work in a janitorial capacity, but do not handle bio-hazardous materials or clean such spills. They have been trained on personal protective equipment, proper cleaning procedures, and general safety. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

(b)(7)(E)

At the time of the survey, (b)(7)(E) The standard is met.

J-C-08 Health Care Liaison (I). Health staff is on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff had received the appropriate orientation. A signed check list is maintained in the employee's personnel file. The orientation lesson plan reviewed at least once every two years by the HSA and facility administrator, most recently in November, 2016. The standard is met.

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El Paso Service Processing Center, TX
February 24, 2017

D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). The on-site pharmacy provides pharmaceutical services that are sufficient to meet the needs of the detainees. Staffing includes (b)(7)(E) (b)(7)(E) Orders are processed in the electronic medical record. The narcotics are stored in a locked narcotic cabinet and counted regularly. We verified the counts during the survey. Medications are dispensed in bottles or plastic bags for the nursing staff, to administer. Stock medications must be signed out of a locked cabinet, and counted each time one is removed. Pharmaceuticals to be disposed of are secured on-site until Reverse Distributors come on-site to destroy them. The pharmacist inspects the medication area and the medication carts monthly, and maintains records as necessary to ensure adequate control of all medications. All medications were stored under proper conditions and an adequate supply of antidotes and other emergency medications was readily available to staff. The standard is met.

J-D-02 Medication Services (E). Medication services are clinically appropriate and provided in a timely, safe, and sufficient manner. Nurses take medication carts to the housing units for administration. The policy identifies the expected time frames from ordering to delivery and a backup plan if the time frames cannot be met. Detainees receive medication within 24 hours if prescribed during regular business hours. If it is not available, it is taken out of stock or obtained from a local pharmacy.

The responsible physician determines the prescriptive practices at this facility. Medications are prescribed only when clinically indicated. Detainees entering the facility on prescription medication continue to receive it or an acceptable alternate medication as clinically indicated. The formulary describes which medications may be classified as "keep-on-person" (KOP) and the detainees must be trustworthy to take their medication correctly. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area includes four examination rooms, office space for a provider, HSA and AHSA, nurse manager, mental health staff, one-chair dental operatory, medical records storage, and a nursing station. Sick call is conducted in a trailer, which has an exam room and a waiting room. Items subject to abuse are inventoried weekly. We verified the accuracy of the counts and confirmed that adequate supplies and equipment, including five automated external defibrillators (AED), were available. The standard is met.

J-D-04 Diagnostic Services (I). On-site diagnostic services include stool blood-testing material, finger-stick blood glucose tests, peak flow meters, multiple-test dipstick urinalysis, and pregnancy tests. An off-site laboratory had been contracted to process the samples. Chest x-rays can be performed on-site, while others are taken at the local hospital. We confirmed that lab and x-ray procedure manuals were available. The CLIA waiver was due to expire on December 23, 2018. The standard is met.

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J-D-05 Hospital and Specialty Care (E). Hospitalization and specialty care is available to patients in need of these services. We verified through record review that off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions. No on-site specialty services were being provided at the time of the survey. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). Detainees receive verbal and written instructions (in English and Spanish) on access to health care services, and the health-related grievance procedures. An access-to-care sign had been posted in the intake area. Interpretation servicescan be provided as needed. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community. Reception personnel identify those individuals in need of emergency care and refer them immediately to a hospital. Their subsequent admission to the facility is predicated on a written medical clearance from the hospital.

Qualified health professionals complete the receiving screening, which includes a disposition and addresses all the required elements, immediately upon detainees' arrival. If a woman reports current opiate use, she is referred immediately for a pregnancy test. All pregnant women who are using opiates are immediately referred to the hospital. Prescribed medications are reviewed and appropriately maintained as clinically indicated. Health staff regularly monitors receiving screenings to determine the safety and effectiveness of the process through the CQI program. The standard is met.

J-E-03 Transfer Screening (E). All new detainees entering the facility are treated as new admissions, even if they are transferring from a different facility. The standard is not applicable.

J-E-04 Initial Health Assessment (E). The full population health assessment has been implemented at this facility. All detainees receive an initial health assessment no later than 14 calendar days after admission. A trained RN completes the hands-on portion of the health assessment, which consists of the required elements, including a review of the receiving screening results and laboratory or diagnostic tests for communicable diseases. TB skin tests or chest x-rays are performed on all detainees. The treating clinician reviews all the positive findings. Specific problems are integrated into an initial problem list, and diagnostic and therapeutic plans for each problem are developed as clinically indicated. The standard is met.

J-E-05 Mental Health Screening and Evaluation (E). A trained RN completes the mental health screening, which includes the required elements, during the initial intake screening. Patients who screen positive on the mental health screening are referred to qualified mental health professionals for further evaluation. The standard is met.

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J-E-06 Oral Care (E). Trained RNs complete the oral screening and provide instructions in oral hygiene and preventive oral education during intake. Oral care is timely and it includes immediate access for urgent or painful conditions. The system of established priorities for oral treatment is not limited to extractions.

However, the dentist does not complete an oral examination within 12 months of detainees' admission. At the time of the survey, we found that 16 detainees had not received their annual oral screening, and were scheduled to be completed the following week. **The standard is not met.**

Corrective action is required for Compliance Indicator #3. (b)(5)

(b)(5)

J-E-07 Nonemergency Health Care Requests and Services (E). All detainees, regardless of housing assignment, have access to regularly scheduled times for routine health care. The frequency and duration of response to requests for health services is sufficient for the detainee population. Open sick call is conducted each morning from 6:00 a.m. until 10:00 a.m. Each barrack is called to send the detainees over to the trailer for sick call. Patients can also request health care by requesting the officer call health services or they can walk into health services at any time. A nurse practioner assists with sick call and sees anyone that the nurse refers the same day. The standard is met.

J-E-08 Emergency Services (E). The RHA maintains emergency drugs, supplies, and medical equipment. Detainees are taken to the hospital by ambulance or facility van. The emergency facility is located five to ten minutes away. We verified that emergency on-call services are available as well. The standard is met.

J-E-09 Segregated Inmates (I). Conditions of segregation at this facility meet NCCHC's category 2b. and require health rounds at least three times per week. In practice, health rounds take place daily and mental health rounds take place weekly. We verified that the rounds are documented in the electronic health record. Upon notification that a detainee has been segregated, qualified health care professionals review the detainee's health record to determine whether there are any contraindications and they also see the detainee in a face-to-face encounter. Health staff informs custody officials of the latest scientific information concerning the health effects of segregation at the medical administrative committee meetings. The standard is met.

J-E-10 Patient Escort (I). Patients are escorted to on-site and off-site clinical appointments in a timely manner. Transporting officers are alerted to special accommodations, such as medication administration. The patient's confidentiality is maintained. The standard is met.

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J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols (Nursing Guidelines) are utilized and do not include prescription medications. The responsible physician and nursing administrator last reviewed them on October 24, 2016. We verified the nurses are trained to use the protocols upon hire and when protocols are revised or introduced. They also undergo annual reviews of competency. The standard is met.

J-E-12 Continuity and Coordination of Care During Incarceration (E). Clinician orders are evidence-based and implemented in a timely manner. Deviations are clinically justified, documented and shared with the patient. Patients receive treatment and diagnostic tests ordered by clinicians, who discuss such care with them. When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard.

The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations (the Bureau of Prisons).

However, while the clinician review diagnostic tests in a timely manner, they are not appropriately acted upon, nor are treatment plans modified as clinically indicated. The clinicians review, but do not always act upon, the recommendations of specialty consultants in a timely manner. Chart reviews are not of sufficient frequency and number to assure that clinically appropriate care is ordered and implemented by attending health staff. **The standard is not met.**

Corrective action is required for Compliance Indicators #3, #7, and #9. (b)(5)

(b)(5)

J-E-13 Discharge Planning (E). The providers and discharge coordinators are involved in discharge planning. Discharging detainees are given a reasonable supply of medication and a referral list. The standard is met.

F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

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J-F-01 Healthy Lifestyle Promotion (I). The RHA utilizes the National Health Education Manual for detainee health education. We confirmed that a variety of health-related brochures and pamphlets is available to all detainees, and that individual health education and instruction in self-care is documented in the health record during clinical encounters. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 100 medical diets were being prepared for patients with specific dietary needs. Detainees who refuse prescribed diets receive receive follow up nutritional counseling. A registered dietitian reviews the medical diet menus at least every six months, most recently on October 15, 2016. Workers who prepare medical diets are supervised while doing so. The standard is met.

J-F-03. Use of Tobacco (I). Smoking is prohibited in all indoor and outdoor areas. Literature on the hazards of tobacco was available to the detainees at the time of the survey. The standard is met.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appears in compliance with current community standards. The responsible physician establishes and annually approves clinical protocols, consistent with national clinical practice guidelines. We verified there were guidelines for all nine diseases, including sickle cell.

The health records documentation confirmed that clinicians follow the chronic disease protocols. The treatment plans include the appropriate elements of frequency of follow-up, monitoring condition, status and taking action as indicated, type and frequency of diagnostic testing and therapeutic regiments, instruction on diet, exercise, medication and adaptation to correctional environment, and clinically justification of deviation from the protocols. Chronic illnesses are listed on the problem list. The RHA maintains a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health condition(s) of the patient, treatment plans define the individual's care. The treatment plans include the frequency of follow-up, type and frequency of diagnostic testing and therapeutic regimens and instructions about diet, exercise, medication, and adaptation to the correctional environment. Special needs are listed on the problem list. The RHA maintains a list of special needs patients. The standard is met.

J-G-03 Infirmary Care (E). The facility had a six-bed medical housing unit at the time of the survey. The level of nursing care provided in the unit does not reach the level of nursing care that would be provided in an infirmary. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Patients with mental health needs are either followed by the psychiatrist, if they are on psychotropic medication, or by the psychologist or social worker. Mental health patients see the psychiatrist every 90 days or they see the psychologist or social worker every 30 days. When clinically appropriate, a patient's commitment

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or transfer to an inpatient psychiatric setting is timely and accomplished according to procedures. Health services are integrated for patient management and to ensure medical and mental health needs are met. Basic on-site outpatient services include the identification and referral of detainees with mental health needs, crisis intervention services, psychotropic medication management when indicated, individual counseling, group counseling, psychosocial/psycho educational programs, and treatment documentation and follow-up. Special programs include: stress groups and sleep disturbance groups. The standard is met.

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence. Patient follow-up occurs as clinically indicated. Suicidal detainees, whether acute or non-acute, are placed on constant observation in the medical housing unit. The officer sits outside of the room with the door open. There have been no suicides at this facility, since it opened. The standard is met.

J-G-06 Patients with Alcohol And Other Drug Problems (AOD) (E). Disorders associated with AOD, such as HIV and liver disease, are recognized and treated. Correctional staff has been trained to recognize detainees' AOD problems. Medical, mental health, and substance abuse staff communicates and coordinates with each other regarding patients' AOD care. Self-help substance abuse programs, on-site individual counseling and group therapy are offered on site. The standard is met.

J-G-07 Intoxication and Withdrawal (E). The responsible physician has approved current protocols, consistent with nationally accepted treatment guidelines for intoxication and withdrawal The protocols were last approved on October 16, 2016. Individuals are housed in the medical housing unit, which allows for effective monitoring by health professionals using recognized standard assessments at appropriate intervals. A physician supervises detoxification.

If a pregnant detainee is admitted with opioid dependence, she is transferred to the hospital for assessment and treatment. The facility's policy addresses the management of detainees, including pregnant detainees, on methadone or similar substances. Therapy is continued in the hospital. Individuals experiencing severe intoxication or withdrawal are transferred immediately to a licensed, acute care facility. The local hospital is utilized. The standard is met.

J-G-08 Contraception (I). Emergency and continuing contraception are available through the on-site pharmacy. Written information about contraception methods and community resources are available. The standard is met.

J-G-09 Counseling And Care Of The Pregnant Inmate (E). Comprehensive counseling services are available to pregnant detainees. The chaplain, mental health, and the obstetrical/gynecological physician discuss pregnancy outcomes with the patient. Prenatal care, specialized obstetrical services, when indicated, and postpartum care are available and documented appropriately. We reviewed a list of pregnancies and transfer dates, as pregnant detainees would be transferred at 25 weeks. The standard is met.

J-G-10 Aids to Impairment (I). We observed detainees using aids to impairment (wheelchairs, canes, hearing aids, and other aids to impairment) during the tour. Health record documentation indicated aids are provided as necessary and nothing had been contraindicated for reasons of

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security. Detainees' special needs are communicated to custody staff in writing. The standard is met.

J-G-11 Care for the Terminally Ill (I). Although it would be rare for a terminally ill patient to be held at this facility, procedures are in place to make the appropriate accommodations for discharge. There have been no terminally ill patients at this facility since it opened. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Detainees' medical and mental health records are integrated into the electronic medical record, which is accessible to all health staff. We confirmed that the record consists of the required elements. The standard is met.

J-H-02 Confidentiality of Health Records (E). Health records are maintained under secure conditions with password protection. Health staff had documented instruction in maintaining patient confidentiality as part of orientation and annually thereafter. If non-health staff transports health records, the records are sealed in an envelope. Custody staff also receives annual confidentiality training. The standard is met.

J-H-03 Management of Health Records (I). The health record is available for each patient care encounter. When a detainee is transferred to another facility, copies of the current health record or a comprehensive health summary accompany them. All of the intra-system facilities have access to the electronic medical record, which is maintained indefinitely, and can be re-activated when the detainee re-enters the system. The standard is met.

J-H-04 Access to Custody Information (I). Qualified health care professionals have access to information in the detainee's custody record when such information may be relevant to the detainee's health and course of treatment. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

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J-I-01 Restraint and Seclusion (E). Clinical restraint and seclusion are not used at this facility, nor are custody-ordered restraints. Anyone known to require restraints or exhibiting behavioral issues would not be sent to this facility and would be transferred should such a need arise. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). Emergency psychotropic medications are not administered at this facility; rather, a detainee requiring such intervention would be transferred to a mental health facility. This has not occurred since the facility opened. Policy and procedure were in place to direct staff in such cases. The standard is met.

J-I-03 Forensic Information (I). Health staff does not collect forensic information; rather, the detainee would be referred off-site for such collection. The standard is met.

J-I-04 End-of-life Decision Making (I). Patients approaching the end of life are permitted to execute advance directives, after being counseled as to the meaning and consequences of such actions. This is documented in the health record. Before utilizing advanced directives, a physician not directly involved in the patient's treatment completes an independent review. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). All informed consents and refusals of care are documented and consist of the required elements, including the signatures of the patient and a health staff witness. Patients are counseled as to possible adverse consequences to health that may occur as a result of a refusal. If the detainee refuses to sign a refusal form, two staff members, one of whom must be health staff, document and witness it. The standard is met.

J-I-06 Medical and Other Research (I). No health-related research is conducted at this facility. The standard is met.

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National Commission on
Correctional Health Care

1145 W Diversey Pkwy
Chicago, Illinois
60614-1318

773-880-1460 phone
773-880-2424 fax
www.ncchc.org

April 24, 2018

(b)(6); (b)(7)(C) MD
500 12th St. SW 2nd Floor
Washington, DC 20536

Dear (b)(6); (b)(7)(C)

Congratulations! The Accreditation Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on April 22, 2018, voted to continue to accredit Tacoma Contract Detention for its compliance with NCCHC's *Standards for Health Services in Jails*. Please find the accreditation report enclosed. Your health services administrator will also receive a copy of the accreditation report and the Certificate of Accreditation.

NCCHC congratulates you on your achievement and wishes you continued success in the future. It is anticipated that the next scheduled on-site survey of the facility will occur sometime prior to January 1, 2021. If we can be of any assistance to you, please feel free to contact us.

Sincerely,

(b)(6); (b)(7)(C) CCHP-RN

(b)(6); (b)(7)(C) RN, CCHP-RN
Vice President, Accreditation

Enclosure

cc (b)(6); (b)(7)(C) MHA, CHE, Chief Executive Officer

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National Commission on Correctional Health Care

ACCREDITATION UPDATE REPORT OF

THE HEALTH CARE SERVICES AT

TACOMA CONTRACT DETENTION

Tacoma, WA

April 22, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

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Tacoma Contract Detention, WA
April 22, 2018

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On January 22-24, 2018, NCCHC conducted its review for continuing accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2014 *Standards for Health Services in Jails* as the basis of its health services analysis. This report focuses primarily on issues in need of correction or enhancement. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

There are 40 essential standards; 39 are applicable to this facility and 39 (100%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include:

Essential Standards Not in Compliance
None

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include:

Important Standards Not in Compliance
None

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: On April 22, 2018, NCCHC's Accreditation Committee awarded the facility Accreditation.

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Tacoma Contract Detention, WA
April 22, 2018

I. Facility Profile

The facility's security classification is: medium
The facility was built in: 2004
There has been no change in mission or purpose.
The facility is located in the northwestern United States.
The facility's supervision style is: Direct Supervision
The facility's structural layout is: Modular and Dormitory-Style Housing
Since the last NCCHC survey, there has no) been any major renovations/expansions/closures in the facility, and none were anticipated.
Total Inmate Count on day of survey: 1452
Total number of adult males on day of the survey: 1316
Total number of adult females on day of the survey: 136
Average Daily Population (ADP) for last completed calendar year: 1398
The design-rated capacity for the facility is: 1575
The population dropped and an officer reduction in force occurred. At the time of the survey, many of the officers were reportedly being rehired.
Admissions to the facility arrive: scheduled mostly in the afternoon.
The total number of admissions to the facility last year was: 6251
The average daily intake to the facility last year was: 18
The total number of correctional staff assigned to this facility is (b)(7)(E)
The usual shift coverage for correctional staff is: three shifts.
There has not been a recent change in health care contractor.
Health services are provided by a national health care vendor.
They have provided health services since: 2004 (inception)
There have not been distinctive events that may affect the delivery of health care
The facility has no satellites.

II. Survey Method

We toured the clinic area, inmate housing areas, intake, medical observation and segregation. We reviewed 31 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; statistical and environmental inspection reports; and health services personnel and CO training records. We interviewed the assistant warden, responsible physician, health services administrator (HSA), other health, mental health, and dental staff, pharmacist, medical records clerk, seven COs, and nine inmates selected at random.

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Tacoma Contract Detention, WA
April 22, 2018

III. Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

The standards in this section address the foundation of a functioning correctional health services system and the interactions between custody and health services authorities. Any model of organization is considered valid, provided the outcome is an integrated system of health care in which medical orders are carried out and documented appropriately and the results are monitored as indicated. Policies and procedures are to include site-specific operating guidelines.

Standard Specific Findings

J-A-01 Access to Care (E). Inmates have access to health care. Patients see a qualified clinician and receive care for their serious medical, mental health, and dental needs. There was no co-pay policy in place at the time of the survey. The responsible physician can authorize all specialty care himself, with no utilization review. Health care is accessible at any time of day. Some inmates are issued special cards to expedite access to medical services if they have special needs, but we verified that all inmates did have prompt access, regardless. The standard is met.

J-A-02 Responsible Health Authority (E). The responsible health authority (RHA) is the full-time HAS (who we verified had a job description. Clinical judgments rest with a designated, full-time responsible physician. There was not a separate structure for mental health services. The LCSW is the designated, full-time mental health clinician. The standard is met.

J-A-03 Medical Autonomy (E). Qualified health care professionals make decisions regarding inmates' serious medical, dental, and mental health needs in the inmates' best interests. We noted good cooperation between custody and medical staff. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. Health staff is subject to the same security regulations as other facility employees. The standard is met.

J-A-04 Administrative Meetings and Reports (E). Weekly "shareholders" meetings are held and include legal counsel, a court representative, field medical coordinator, on-site medical staff such as the HSA and clinical director, detention services manager, the warden and associates, contract officers, and others. The quarterly governing board meetings include regional managers and all department heads of disciplines. They develop graphs, look at trends, and evaluate cost effectiveness and service delivery flow, amongst other items. The findings are subsequently shared with all staff. Other meetings include those for special case review classification, and special care committee.

Health staff meets monthly to discuss health services operations. Attendees include the responsible physician, HSA, mental health, dental, and nursing staff. Statistical reports of health services are made at least monthly and provided to the facility administrator. They are used to monitor trends in the delivery of health care. We reviewed the health staff meeting minutes, as well as the statistical reports. The standard is met.

J-A-05 Policies and Procedures (E). The health services policy manual is site-specific. We also reviewed the national policies which the RHA has signed annually and local operating procedures. The RHA and responsible physician last reviewed the manual in 2017. The policies were accessible to health staff. The standard is met.

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J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee meets quarterly and consists of the responsible physician, HSA, mental health representatives, compliance officer, two assistant HSAs, public health safety and preparedness officer, pharmacist, dentist, training officer and CQI nurse. The committee is chaired by the CQI coordinator. The agenda includes routine reviews of grievances, suicides, mortality reviews and other incident reports. Trends are all reviewed.

A variety of process studies have been completed since the last survey. Studies in 2017 included intake screening results from referral, medication refusal, informing providers, and follow up. An outcome study examined inmates and weight gain after incarceration and after a number of months in the facility. The diet was reviewed and results included change in diet calorie count by approximately 200 to 400 calories. An overall healthier diet resulted in less inmate weight gain than in the past.

In 2016, studies included an outcome study for TB management, and hyperlipidemia. Process studies included suicide watch examination and special diets related to allergies. A 2018 binder included documentation injuries to workers and recreation-related injuries.

We verified that the program has been reviewed annually for its effectiveness. The responsible physician is involved in the CQI program and attends committee meetings. The standard is met.

J-A-07 Emergency Response Plan (E). The RHA and facility administrator have approved the health aspects of the emergency response plan, which included the required elements. Multiple casualty disaster drills have been held annually so that over the course of three years, staff on each shift has had an opportunity to participate. The scenarios included: simulated explosions, an active shooter, and a disturbance by protesters at the facility. The drills were well critiqued and the results were shared with the health staff.

Man-down drills/events have been documented and confirmed that health staff on each shift has been able to participate annually. Staff actually practice man-down drills monthly. They have been well critiqued and shared with all health staff. The standard is met.

J-A-08 Communication on Patients' Health Needs (E). Communication between designated correctional and health services staff about inmates' special health needs occurs electronically and in writing. The inmate also gets a copy. The standard is met.

J-A-09 Privacy of Care (I). Clinical encounters and discussion of patient information are conducted in auditory and visual privacy. Magnetic privacy covers are placed on the exam room windows if needed. Security personnel are present only if the patient poses a probable risk to the safety of the health care professional or others. The standard is met.

J-A-10 Procedure in the Event of an Inmate Death (I). Since the last survey, there have been no inmate deaths. Policy includes the required reviews to be completed in a timely manner in the event of an inmate death. The standard is met.

J-A-11 Grievance Mechanism for Health Complaints (I). The health-related grievance program is separate from the formal grievance program. Staff will attempt to intervene and

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resolve issues informally, if possible. The assistant HSA responds to most grievances within five business days. Appeals are answered within 72 hours, with most being treated as urgent. There has not been an appeal in the past two years. On average, 14 health-related grievances are filed per month. They are tracked monthly and reviewed in CQI meetings. Trends are reviewed and categorized. The standard is met.

B. MANAGING A SAFE AND HEALTHY ENVIRONMENT

The standards in this section address the importance of preventative monitoring of the physical plant. Health staff has a crucial role in identifying issues that could have a negative impact on the health and safety of facility staff and the inmate population if left unaddressed.

Standard Specific Findings

J-B-01 Infection Prevention and Control Program (E). The responsible physician has approved the written exposure control plan, which is updated annually, most recently on January 17, 2017. Infection control matters are addressed at CQI and health staff meetings. Patients are screened for STD based upon symptomatology and request. If necessary, they can be treated in one of the four on-site medical isolation rooms. During the survey, three of the rooms were in use to rule out tuberculosis. Nurses conduct a daily tissue test and record the digital monitor results. Custody staff are responsible to routinely monitor and change the filters in the rooms. Monthly and annual inspections monitor such equipment as autoclaves, centrifuge, ophthalmoscopes, etc., and repair plans are implemented as necessary.

Effective ectoparasite control procedures are used to treat infected inmates. The health services area is inspected monthly for environmental concerns. Inmates receive immunizations for flu, varicella, and HIV. The standard is met.

J-B-02 Patient Safety (I). Patient safety systems were in place to prevent adverse and near-miss clinical events. Staff can report incidents in a non-punitive environment. Medication errors are tracked electronically as "incident reports," which the HSA, CQI nurse, and corporate staff review. A 2017 implementation of the electronic medication administration record has reduced errors to an average of one a month. The standard is met.

J-B-03 Staff Safety (I). Health staff appears to work under safe and sanitary conditions. Safety and cleanliness checks are routinely conducted and documented. All inspection results are tracked. We found the facility to be very clean. Staff training is conducted throughout the year. The standard is met.

J-B-04 Federal Sexual Abuse Regulations (E). The assistant warden described the facility as compliant with the 2003 Federal Prison Rape Elimination Act (PREA). Written policies and procedures address the detection, prevention and reduction of sexual abuse. The PREA audit was successfully completed in March 2017. All inmates are screened for PREA at intake, and we observed informational posters throughout the facility. The standard is met.

J-B-05 Response to Sexual Abuse (I). All health staff have been trained in how to detect, assess, and respond to signs of sexual abuse and sexual harassment, as well as evidence preservation. The training includes a post-test to evaluate comprehension.

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Victims of sexual assault are referred to a community hospital for treatment and evidence collection by a SANE nurse. In all cases, the victim is evaluated by a qualified mental health professional and a report is made to correctional authorities to affect a housing separation of the victim from the assailant. There has been no reported assault in the past three years. The standard is met.

C. PERSONNEL AND TRAINING

The standards in this section address the need for a staffing plan adequate to meet the needs of the inmate population, and appropriately trained and credentialed health staff. Correctional officers are to have a minimum amount of health-related training in order to step in during an emergency, if health staff is not immediately available.

Standard Specific Findings

J-C-01 Credentials (E). Health care personnel, including contractors, who provide services to inmates had credentials and were providing services consistent with the jurisdiction's licensure, certification, and registration requirements. The HSA and corporate staff are responsible for the credential verification process, which includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank. This is documented electronically. The standard is met.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN), and licensed practical nurses (LPN), including contracted staff.

A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed an electronic record listing the names of the individuals being reviewed and the date of their most recent review, which included required elements. The standard is met.

J-C-03 Professional Development (E). We confirmed that qualified health care professionals had more than the required number of continuing education credits. All were current in cardiopulmonary resuscitation (CPR) training. Additionally, staff who maintain a current license must meet the state requirement. By facility policy, 40 hours of training is required, which the staff also met. We confirmed compliance by reviewing a list of completed courses, dates, and number of hours per course for each employee. The standard is met.

J-C-04 Health Training for Correctional Officers (E). Correctional staff had the required training in health-related topics, and at least 75% were current in their health-related training. Officers carry current CPR cards on their person. We verified training by reviewing the attendance rosters and schedules. We reviewed the training outline, including course content and length, and confirmed it included all the required topics. Officers receive annual training in suicide prevention, medical, mental health, screening, STDs, special needs, and other topics. The RHA and corporate representatives had approved and signed the training documentation. The standard is met.

J-C-05 Medication Administration Training (E). Nurses administer medications. Their training, which the facility administrator and responsible physician had approved, includes

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matters of security, accountability, common side effects, and documentation. It is part of orientation and reviewed annually thereafter. The standard is met.

J-C-06 Inmate Workers (E). Inmate workers do not provide health services, nor are they involved in peer health-related programs. They work only in a janitorial capacity or in the laundry, and do not handle biohazardous materials or clean such spills. The standard is met.

J-C-07 Staffing (I). Full-time equivalent health staff includes:

(b)(7)(E)

At the time of the survey, there were (b)(7)(E) health staff. The following health staff positions were vacant: (b)(7)(E) The standard is met.

J-C-08 Health Care Liaison (I). Heath staff is on site 24 hours a day. The standard is not applicable.

J-C-09 Orientation for Health Staff (I). We confirmed that health staff had received the appropriate orientation within 90 days of employment. It includes two weeks of orientation and self-study, policies, videos and webinars, followed by two weeks of on-the-job training, rotating to gain exposure to all areas of health services. The preceptors verify completion of orientation.

The corporate clinical director and on-site RHA review the lesson plans at least every two years. The standard is met.

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D. HEALTH CARE SERVICES AND SUPPORT

The standards in this section address the manner in which health services are delivered–the adequacy of space, the availability and adequacy of materials, and, when necessary, documented agreements with community providers for health services.

Standard Specific Findings

J-D-01 Pharmaceutical Operations (E). A national vendor provides pharmaceutical services that are sufficient to meet the inmates' needs. The clinic includes a spacious pharmacy, and a separate medication room. A full-time pharmacist dispenses medications in patient-specific bottles within one day or less of providers' orders. There is an afterhours locked box for emergencies outside of the pharmacy for those medications that cannot wait until the following day. Stock prescriptions are secured here for the night shift nurses when the pharmacist leaves each day, and he checks it in the morning. The pharmacist maintains routine monitoring and inspection schedules, as well as records to ensure adequate control of and accountability for all medications, including stock. The federal pharmacy requires no state license, but a DEA license was due to expire on November 30, 2018. We verified that the pharmacist and the pharmacy technician maintain control of all medications, which we verified to be stored under proper conditions. An adequate supply of antidotes and other emergency medications was readily available to staff. The standard is met.

J-D-02 Medication Services (E). Medication services are clinically appropriate and provided in a timely, safe and sufficient manner. Nurses conduct "pill line" three times a day, and go to the segregation area three times a day a well. The policy identifies the expected time frames from ordering to delivery, and a backup plan if the time frames cannot be met. Generally, medication orders are delivered within 24 hours. The responsible physician determines the prescriptive practices at this facility. Medications are prescribed only when clinically indicated. Inmates entering the facility on prescription medication continue to receive the medication or acceptable alternate medication as clinically indicated. The physician verifies it and provides a new order. The keep-on-person program was extensive, allowing inmates to keep most medications, including those for chronic care, on their persons. Psychotropic medications, however, were not part of the program. The standard is met.

J-D-03 Clinic Space, Equipment, and Supplies (I). The clinic area was spacious and included seven examination rooms, multiple offices and cubicle space for mental health and administrative staff, a break room, a two-chair dental operatory, panorex and dental x-ray equipment, medical records storage, a laboratory, an x-ray room with digital x-ray, an urgent care triage room, and a pharmacy and medication room. Items subject to abuse are inventoried each shift. We verified the accuracy of the counts, and confirmed that adequate supplies and equipment, including an automated external defibrillator in the clinic and two others in the facility, were available. We found the clinic to be well organized and clean. The standard is met.

J-D-04 Diagnostic Services (I). On-site diagnostic services include stool blood-testing material, finger-stick blood glucose tests, peak flow meters, multiple-test dipstick urinalysis, and pregnancy tests. Laboratory services were provided by a contracted vendor. Chest x-rays can be taken on site, while other x-ray needs are met at the local hospital. We verified that each service had a procedure manual that included the protocols for testing device calibration. The CLIA waiver was due to expire on February 11, 2020. The standard is met.

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J-D-05 Hospital and Specialty Care (E). Hospitalization and specialty care is available to patients in need of these services. Several local hospitals can be consulted as needed. We verified through record review that off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions. At the time of the survey, there were no on-site specialty services used regularly for medical or mental health care. The standard is met.

E. INMATE CARE AND TREATMENT

The standards in this section address the core of a health services program: that all inmates have access to health services, how they are to request emergency and non-emergency care, that health histories are obtained, that assessments and care can be demonstrated to be provided in a timely fashion, and that discharge planning is considered. In short, health care for the inmates is to be consistent with current community standards of care.

Standard Specific Findings

J-E-01 Information on Health Services (E). During intake, inmates receive verbal and written instructions in English and Spanish on access to care and health-related grievances. The inmate population speaks several languages, arrangements were in place to provide interpretation assistance as needed. Accommodations are also made for the hearing impaired. We observed access-to-care signs had been posted in the intake area. Other efforts to educate the inmate population included showing videos in the housing areas, and weekly briefings by health staff. The standard is met.

J-E-02 Receiving Screening (E). New admissions arrive directly from the community or an ICE facility or local jail. Reception personnel identify those individuals in serious need and refer them immediately to a local hospital. Their subsequent admission to the facility is predicated on a written medical clearance from the hospital. The clinic is adjacent to the intake area and nurses are available for screening 24 hours a day. Officers can request that a nurse prescreen if there are any immediate concerns.

Receiving screening is completed by a nurse (RN and LPN), who generally attempts to screen within 15 minutes of arrival. Our review found the screenings to be timely, generally within one to three hours, and comprehensive, consisting of a disposition and addressing the required areas of inquiry.

If a woman reports current opiate use, she is referred immediately for a pregnancy test. A pregnant inmate would not remain at this facility, but a transfer would be processed the same day. Prescribed medications are reviewed and maintained as clinically indicated. Health staff regularly monitors receiving screenings through the CQI process to determine the safety and effectiveness of the process through CQI. The standard is met.

J-E-03 Transfer Screening (E). Qualified health care professionals review each transferred inmate's health record or summary within 12 hours of arrival to ensure continuity of care. Receiving screening is completed for all incoming inmates, regarding medications and any follow-up or pending medical needs and visits. The standard is met.

J-E-04 Initial Health Assessment (E). The full population has been implemented at this facility. Health assessments were timely and completed within one day of arrival. A trained RN

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completes health assessments on inmates with non-complicated cases, while the mid-level provider or physician does so for those with chronic care or mental health issues. The physician reviews and signs assessments conducted by the RN or a mid-level provider.

We verified that the health assessment consists of the required elements, including a review of the receiving screening results, and laboratory or diagnostic tests for communicable diseases STDs, hepatitis, etc., based upon risk factors.

The treating clinician reviews all positive findings and specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem are developed as clinically indicated. The standard is met.

J-E-05 Mental Health Screening and Evaluation (E). A trained nurse completes the mental health screening during intake. We verified that it consists of the required areas of inquiry. Patients with positive results are referred to qualified mental health professionals for further evaluation. The staff are either psychologist-level or licensed social workers. These patients receive a full mental health clinical assessment within 72 hours of referral. All patients are assessed for stress and sleep. The standard is met.

J-E-06 Oral Care (E). A trained nurse or provider completes the oral screening during the health assessment. Inmates are also instructed in oral hygiene and preventive oral education during the health assessment. Oral education is also described in the inmate handbook. The dentist regularly schedules inmates in advance and completes an oral examination within 12 months of admission. Staffing includes (b)(7)(E). We found oral care to be timely, and the system of established priorities for oral treatment included cleaning, root canals, and fillings. The standard is met.

J-E-07 Nonemergency Health Care Requests and Services (E). All inmates, regardless of housing assignment, have access to regularly scheduled times for routine health care. The frequency and duration of response to requests for health services is sufficient for the inmate population. Nurses collect slips or record verbal requests daily in the early morning hours in each housing unit. This includes segregation. An RN triages the requests the same day, and patients are seen either that day or the next. If triage requires a face-to-face assessment, the inmate is seen in sick call generally the same day. Patients can access the clinic daily. The standard is met.

J-E-08 Emergency Services (E). The RHA maintains emergency drugs, supplies, and medical equipment. On-call services are available, and the local 911 service can be activated if necessary. The internal policy requires a four-minute response time that is monitored. The standard is met.

J-E-09 Segregated Inmates (I). Conditions of segregation at this facility (NCCHC's category 2b) require health rounds at least three times a week. In practice, nurses conduct daily rounds, and mental health staff does so weekly. We verified that the rounds are documented and scanned into the health record. Upon notification that an inmate has been segregated, nurses interview the inmate in the clinic and also review the health record for possible contraindications. Inmates must be cleared for segregation.

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Health staff inform custody officials of the latest scientific information concerning the health effects of segregation. Weekly meetings are held to discuss segregated inmates. These are attended by the warden, director of mental health, medical representative, the lieutenant in charge of segregation, and the chief of security. Since many inmates housed in segregation have mental health issues, they are reviewed for any decompensation and socialization needs, and to ensure that efforts are made to mitigate effects of 23 hours of "lock down." Officers who work in segregation also receive additional training in medical, screening and mental health areas. The 20 cells were occupied during the survey. The standard is met.

J-E-10 Patient Escort (I). Patients are escorted to on-site and off-site clinical appointments in a timely manner. Transporting officers are alerted to special accommodations such as medication administration when necessary, and patient confidentiality is maintained. Some special needs patients are issued "medical pink cards" that allow them expedient access to be taken to the clinic without questioning or delay, such as seizure patients. Officers have been trained to expedite escort anytime the pink card is presented to them. The standard is met.

J-E-11 Nursing Assessment Protocols (I). Nursing assessment protocols are utilized, and they do not include prescription medications. The local emergency service would be activated in a life-threatening situation. The responsible physician and nursing administrator last reviewed the protocols on November 9, 2017. We verified that the nurses are trained to use the protocols upon hire and when protocols are introduced or revised. Nurses must take an annual written test, which the RHA reviews and signs. The standard is met.

J-E-12 Continuity and Coordination of Care During Incarceration (E). We confirmed that continuity of care is appropriate. Clinician orders are evidence-based and are implemented in a timely manner. Any deviations are clinically justified, documented and shared with the patient. The clinician reviews diagnostic tests in a timely manner, and signs all labs, outside visits and outside care. Treatment plans are modified as clinically indicated.

Patients receive treatment and diagnostic tests ordered by clinicians, who discuss such care with them. When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard. The clinician reviews and acts upon specialty consultants' recommendations in a timely manner.

The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations. All patients receive annual physical exams.

Chart reviews are of sufficient number and frequency to assure that clinically appropriate care is ordered and implemented by attending health staff. The standard is met.

J-E-13 Discharge Planning (E). Arrangements are made for discharging inmates to have a reasonable supply of medication from 7 days to as much as thirty days. Health staff work with consulates in various countries to connect inmates with health care departments in the receiving country through the internet. The standard is met.

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F. HEALTH PROMOTION AND DISEASE PREVENTION

The standards in this section address health and lifestyle education and practices, as well as patient-specific instruction during clinical encounters.

Standard Specific Findings

J-F-01 Healthy Lifestyle Promotion (I). A variety of health-related brochures and pamphlets was evident, and in a variety of languages. We observed through health record review that individual health education and instruction in self-care is documented in the health record progress notes during clinical encounters. The standard is met.

J-F-02 Medical Diets (I). At the time of the survey, approximately 81 medical diets were being prepared for patients with specific dietary needs. Inmates who refuse prescribed diets receive follow up nutritional counseling. A registered dietitian reviews the medical diet menus at least every six months, most recently on November 5, 2017. Staff kitchen workers prepare medical diets. Inmates who are kitchen workers are supervised while performing their duties, but do not prepare the diets. The standard is met.

J-F-03 Use of Tobacco (I). Smoking is prohibited indoors, although staff may smoke outdoors in designated areas. Inmates are not permitted to smoke. Information on the health hazards of tobacco was evident. The standard is met.

G. SPECIAL NEEDS AND SERVICES

The standards in this section address the needs of inmates with chronic conditions or other health conditions that require a multidisciplinary approach to treatment. These special needs include mental health issues.

Standard Specific Findings

J-G-01 Chronic Disease Services (E). Care as reflected in the health record appeared in compliance with current community standards. Chronic care patients are promptly identified and scheduled for medical evaluation and follow-up care. The responsible physician establishes and annually approves clinical protocols consistent with national clinical practice guidelines (a compilation of guidelines, including the Bureau of Prisons, ICE Department of Health Services, CDC, NIH and other national organizations).

Health records documentation confirmed that clinicians follow the chronic disease protocols. The treatment plans include the appropriate elements (frequency of follow-up; monitoring condition and status and acting as indicated; type and frequency of diagnostic testing and therapeutic regiments; instruction on diet, exercise, medication and adaptation to correctional environment; and clinical justification of deviation from the protocols). Chronic illnesses were listed on the problem list and we verified that the RHA maintains a list of chronic care patients. The standard is met.

J-G-02 Patients With Special Health Needs (E). When required by the health condition(s) of the patient, treatment plans define the individual's care, and include the frequency of follow-up; type and frequency of diagnostic testing and therapeutic regimes; and instructions about diet,

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exercise, adaptation to the correctional environment and medication. Special needs are listed on the problem list and we verified that the RHA maintains a list of special needs patients. Mental health staff develops treatment plans for their patients in accordance with policy. The standard is met.

J-G-03 Infirmary Care (E). There was no infirmary at the time of the survey. The medical housing unit consisted of eight rooms in close proximity to the clinic. Both medical and psychiatric patients are managed in this area. Inmates with serious conditions are sent to a hospital or other appropriate facility. The standard is not applicable.

J-G-04 Basic Mental Health Services (E). Mental health coverage is available 12 hours daily. Staffing consists of (b)(7)(E)
While there was no special mental health unit, patients may be assigned to the medical observation area. Segregation is used for overflow as well. Officers who work in segregation receive additional training in responding to mentally ill patients.

Patients with acute mental health needs are referred to appropriate alternative facilities. When clinically appropriate, a patient's psychiatric commitment or transfer to an inpatient psychiatric setting is timely and accomplished with assistance to a facility in another state, if necessary.

Outpatients receiving basic mental health services are seen at least every 90 days or as clinically indicated. Mental health, medical and program services are coordinated to facilitate integrated patient management, and to ensure patients' medical and mental health needs are met. Psychoeducational programs include chess facilitated by a psychiatrist with tournaments and unit team building. Custody-operated programs address nontherapeutic activities. The standard is met.

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence. Patient follow-up occurs as clinically indicated. Acutely suicidal inmates are placed on constant observation. Officers conduct one-on-one monitoring in the medical observation area. Non-acutely suicidal inmates are monitored on an unpredictable, staggered schedule not exceed 15 minutes. If the non-acutely suicidal inmate is placed in an isolation cell, constant observation is maintained. We reviewed a printout of the officers' electronic monitor use. Only the psychiatrist may remove someone from suicide watch within the first 24 hours. Mental health staff may then assess and remove the inmate as needed.

There have been no suicides since the last survey. During the survey, there was one inmate on non-acute watch located in the medical observation unit. The standard is met.

J-G-06 Patients with Alcohol And Other Drug Problems (AOD) (E). Disorders associated with AOD, such as HIV and liver disease, are recognized and treated. Correctional staff had been trained to recognize inmates' AOD problems. Medical, mental health, and program staff communicates and coordinates with each other regarding patients' AOD care. There were no formal substance abuse programs on site at the time of the survey. Self-help substance abuse videos and workbooks were evident. Custody staff operates groups, primarily recreational in nature, to allow socializing with incentive programs. The standard is met.

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J-G-07 Intoxication and Withdrawal (E). The responsible physician has approved current protocols consistent with nationally accepted treatment guidelines for intoxication and withdrawal. The protocols were last approved in 2017. Individuals are housed in a safe location that allows for effective monitoring by health professionals using recognized standard assessments at appropriate intervals. A physician supervises detoxification. This facility does not incur a large population with intoxication and withdrawal problems. Those who meet the limited thresholds established with COWS and CIWA scales are transferred to another facility or the hospital. Individuals experiencing severe intoxication or withdrawal are transferred immediately to a licensed, acute care facility.

If a pregnant inmate is admitted with opioid dependence, she is assessed and transferred to the hospital. Such patients are not treated at this facility, although the policy complies with the standard. There was no inmate on detoxification status during the survey. Such patients would generally be placed in medical observation. The standard is met.

J-G-08 Contraception (I). Emergency contraception is available by policy, although reportedly it is has never been requested. Continuing contraception is available as well. Reference material about contraception methods and community resources was evident. The standard is met.

J-G-09 Counseling And Care Of The Pregnant Inmate (E). Comprehensive counseling services are available to pregnant inmates through the obstetrical/gynecological provider, as are prenatal care, specialized obstetrical services when indicated, and postpartum care. No inmate has delivered while at this facility. During the survey there was only one pregnant inmate on site. Pregnant inmates are often transferred to the hospital for their incarceration and delivery and do not remain in this facility for any long-term pregnancy. By policy, restraints are not used during active labor and delivery. The standard is met.

J-G-10 Aids to Impairment (I). We did not observe inmates using aids to impairment during the tour. However, aids such as wheelchairs, crutches, etc. are said to be available if needed. Health records documentation indicated that aids are provided as necessary. When specific aids are contraindicated for security reasons, alternatives are considered. The standard is met.

J-G-11 Care for the Terminally Ill (I). Although it would be rare for a terminally ill patient to be held at this facility, procedures were in place to make the appropriate accommodations including transfer to an appropriate hospital or long-term care facility. Policy states that palliative therapies would be provided for terminally ill patients. The standard is met.

H. HEALTH RECORDS

The standards in this section address the importance of accurate health record documentation, health record organization and accessibility, and need to ensure that medical and mental health information is communicated when those records are separate documents.

Standard Specific Findings

J-H-01 Health Record Format and Contents (E). Inmates' medical, dental and mental health records are integrated in electronic format. The health record includes a problem list, as well as all other critical elements. The standard is met.

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J-H-02 Confidentiality of Health Records (E). Health records are maintained under secure conditions with password protection, and locked in archival areas. Health and custody staff had documented instruction in maintaining patient confidentiality. If non-health staff carries health records, the records are secure, and marked "confidential." Most records are transferred electronically. The standard is met.

J-H-03 Management of Health Records (I). The health record is available for each patient care encounter. Each exam room was equipped with computers, and we also observed laptops in use. The building was also equipped with wireless connectivity. When an inmate is transferred to another facility, a comprehensive health summary generally accompanies them electronically. The jurisdiction's legal requirements regarding records retention are followed. We confirmed that health records can be reactivated when a treating health professional requests it. The standard is met.

J-H-04 Access to Custody Information (I). Qualified health care professionals have access to information in the inmate's custody record when such information may be relevant to the inmate's health and course of treatment. The standard is met.

I. MEDICAL-LEGAL ISSUES

The standards in this section address the most complex issues facing correctional health care providers. While the rights of inmate-patients in a correctional setting are generally the same as those of a patient in the free world, the correctional setting often adds additional considerations when patient care is decided. The rights of the patient, and the duty to protect that patient and others, may conflict; however, ethical guidelines, professional practice standards, and NCCHC's standards are the determining factors regarding these interventions and issues.

Standard Specific Findings

J-I-01 Restraint and Seclusion (E). Clinical restraint and seclusion is rarely ordered for patients who exhibit behavior that is dangerous to self or others as a result of medical or mental illness. Policies and procedures were appropriate. In the past three years, three patients had been restrained for medical reasons and this was carried out in the medical observation rooms. Medical staff was present, and we verified that the monitoring was well documented. The physician order was comprehensive. Preventing self-harm was the reason given in two cases.

Custody-ordered restraints are also rarely applied, and health staff would be notified for reasons of documentation and monitoring the inmate's health status. The physician would be notified immediately should the inmate develop a medical or mental health condition. If health staff notes improper restraint use that is jeopardizing the health of the inmate, they communicate this to the appropriate custody staff. The standard is met.

J-I-02 Emergency Psychotropic Medication (E). The use of forced psychotropic medication is not implemented at this facility; rather, a court order must be obtained prior to use. It was reported that the patient would be sent to the hospital for acute psychiatric care. The standard is met.

J-I-03 Forensic Information (I). Health staff does not collect forensic information at this facility. The standard is met.

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J-I-04 End-of-life Decision Making (I). Although terminal patients do not remain at this facility, they would be permitted to execute advance directives. The policy was very comprehensive and required that patients be counseled as to the meaning and consequences of such actions, and that counseling to be documented in the health record. A physician not directly involved in the patient's care would first complete an independent review. The standard is met.

J-I-05 Informed Consent and Right to Refuse (I). All informed consents and refusals of care were documented in the health record and consisted of the required elements, including the signatures of the patient and a health staff witness. Significant refusals would result in an appointment with a medical staff for counseling as to possible adverse consequences to health that may occur as a result of a refusal. If the inmate refuses to sign a refusal form, it would be documented by a health staff member. The standard is met.

J-I-06 Medical and Other Research (I). No health-related research is conducted at this facility. The standard is met.

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The Nakamoto Group, Inc.

March 14, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Rio Grande Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2008 of the Rio Grande Detention Center in Laredo, TX, during the period of March 12-14, 2019. This is an IGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2008 for Over 72 hour facilities. The facility received a rating of Meets Standards during the March 2018 inspection.

Inspection Summary

The Rio Grande Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2008 compliance annual inspections:

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2018 Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2019 Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

The inspection team identified four (4) component deficiencies in the following two (2) standards:

Medical Care – 1, which is a repeat deficiency
Detainee Handbook – 3

Facility Snapshot/Description

The Rio Grande Detention Center is operated by The GEO Group, Inc. The facility is located fifteen miles south of Laredo, Texas bordering the Rio Grande River and Mexico. It has a rated capacity of 1900. The facility houses low custody level adult male ICE detainees and male and female U.S. Marshals Service detainees of all custody levels. ICE detainees are kept separate from non-ICE detainees. During the inspection the average daily population of the facility was 1681 of which 600 were ICE detainees. The average length of stay for an ICE detainee is 22 days.

The compound is comprised of eight structures. (b)(7)(E)
(b)(7)(E)
(b)(7)(E)

There is one administrative building and one maintenance building located outside the secure fenced perimeter. Inside the secure perimeter there is one support services building, which also houses the female special management population, five general population housing units configured into dormitory settings ranging from 64 to 84 beds and one male special management unit. Two of the housing units are dedicated to ICE detainees. Housing unit day rooms are furnished with televisions, telephones, fixed tables and seats and ample open space. Each detainee is assigned a personal unsecured property storage bin; locks are not provided. During the inspection two of the housing units, one ICE and one non-ICE, were quarantined due to a mumps outbreak.

The inspection team toured the housing units' multiple times during the inspection and detainees were interviewed each time. Interviews involved LEP and English-speaking detainees. Interpreters and the language line were used when canvassing detainees. None of the detainees expressed any concerns about their treatment or safety. There were no complaints about the quality of the food, medical care, access to recreation, the law library, telephones, visiting or ICE personnel. Detainees were satisfied with all conditions of their confinement.

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The atmosphere in the housing units was relaxed and quiet. The majority of security staff are bilingual. The cleanliness inside the living units, including showers and bathrooms was average. A case manager is assigned to each housing unit and maintains office space in the unit. ICE personnel are generally onsite five days a week. Facility command staff make shift rounds through each housing unit daily.

Medical services are provided by Wellpath personnel. There are no medical co-payments. Food and maintenance services are provided by GEO personnel. The overall facility maintains an average level of cleanliness.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2008. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	March 14, 2019
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

October 11, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Adelanto ICE Processing Center East**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Adelanto ICE Processing Center East in Adelanto, CA during the period of October 9-11, 2018. This is an DIGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the October 2017 annual inspection.

Inspection Summary

The Adelanto ICE Processing Center East is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS annual compliance inspections:

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2017 Annual Inspection	
Meets Standards	40
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	2

2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	2

The inspection team identified one (1) deficient component in the following standard:

Funds and Personal Property- 1, which is a repeat deficiency

Facility Snapshot/Description

The Adelanto ICE Processing Center East is located in the high desert southwest region of Adelanto, California, neighboring other correctional facilities and government buildings. The Adelanto ICE Processing Center East is owned and operated by the Geo Group, Inc. The Geo Group has an intergovernmental services agreement with ICE and the City of Adelanto, California. The facility is a Dedicated IGSA facility housing male and female detainees of all classification levels. During the inspection the count was 529, with 276 male and 253 female detainees. The average length of stay is 72 days.

Adelanto East consists of direct supervision dormitory-style housing. (b)(7)(E) (b)(7)(E) Dayroom areas provide adequate open space and sedentary activities such as television viewing and card games. Detainees spend the majority of their time socializing in the dayrooms, watching television, working, or participating in indoor/outdoor recreation activities. There is a large outdoor recreation area, as well as two smaller areas, which are available to detainees on a daily basis. Recreation is offered at the optimal level. The atmosphere throughout the facility was relaxed. Interactions among the staff and detainees was professionally courteous, as observed by the inspection team. There are kiosks in each housing unit programmed with LexisNexis. Detainees have access to the kiosks 24 hours per day, seven days per week. This feature, combined with the main law libraries' hours, provide optimal access to legal services for detainees.

Without exception, detainees stated that they feel safe at the facility. Detainees freely approached the inspectors to converse and no less than 71 detainees were interviewed during the inspection, 26 of which were formal confidential interviews. The language line was used as necessary. LEP detainees stated that they had no issues obtaining services. Confidential interviews revealed no concerns. Two detainees complained that one officer did not treat them with respect, but they had not filed any complaints or grievances about the officer. The detainees were advised of the processes for filing grievances to ICE and contacting the OIG. One detainee complained that they had not seen their ICE officer. Logs and visiting liaison checklists combined to indicate that ICE officers had been in the housing unit to interview detainees at least weekly during the inspection period. The detainee was advised to send a request form to ICE to guarantee an interview. One detainee asked about the permissibility of crafts for recreation in the housing units, and she was referred to facility staff. There were seven complaints regarding medical services. One was about the lack of an eye exam, for which the detainee was already scheduled. Three were regarding the lack of follow-up appointments, and the Medical SME determined that all three were scheduled for follow-up appointments the next day. One complained that her medication had been taken by staff, and the Medical Inspector learned that the medication was expired and had to be re-issued. One detainee stated that she had a rash, and it was discovered that she is currently receiving medical care for the rash. The last complaint was about a follow-up appointment for a toothache. The Medical Inspector found that the detainee is scheduled for an appointment with an oral surgeon.

Facility employees appeared and conducted themselves professionally, and most seemed to understand the requirements of the standards. Many of the staff are bilingual.

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There is no medical co-pay. Medical services are provided by Correct Care Solutions. All other services are provided by GEO Group employees.

Areas of Concern/Significant Observations

ICE and facility staff expressed concerns over the recent OIG report in terms of the characterizations of certain information and erroneous reporting. Of note were the OIG's reference to "nooses" in the living areas. Examination of the pictures presented as evidence in the report indicated that the sheets were being used as privacy curtains or clotheslines, and were tied up loosely so that they could be easily pulled down for use by the detainees. The local staff indicated that they explained this to the OIG inspectors, but nonetheless they chose to use the inflammatory term of "nooses", even though there was no question about the purpose of the sheets. The OIG report also tied the privacy curtains and clotheslines to suicide prevention, when in fact there was no evidence to suggest that any privacy curtain or clothesline was used for such purposes. In the expert judgement of the inspection team, this mischaracterization in the OIG report only serves to exaggerate a housekeeping infraction. There were no makeshift clotheslines or privacy curtains observed during this inspection.

The OIG report also stated there had been no dental fillings or cleanings performed by the dental staff for the past four years; and that a dentist indicated that detainees could use strings from their socks as dental floss. Records revealed that a number of cleanings and fillings had been completed during the months prior to the OIG inspection, and have continued throughout the inspection period. Further, the witnessing staff indicated that the dentist was relaying a story from his past employment at a state correctional facility when he talked about threads being used as dental floss. He never suggested that detainees should do so.

The G-324 records more examples of inaccurately reported findings in the recent OIG report, to include those regarding the presence of segregation orders and medical rounds in segregation. It would be advantageous for OIG to use inspectors with detention and corrections backgrounds for future inspections to avoid this type of embarrassment to their office and ICE, especially since the inaccuracies have now been reported by the news media as fact.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Acceptable. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). The remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An outbrief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

ICE Officials – FOD Thomas Giles (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)

Facility Staff – Warden James Janecka, (b)(6); (b)(7)(C)
and various supervisors and staff

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(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — October 11, 2018

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

October 5, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Adelanto ICE Processing Center West**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Adelanto ICE Processing Center West in Adelanto, CA during the period of October 3-5, 2017. This is a DIGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility was rated Meets Standards during the October 2016 inspection.

Inspection Summary

The Adelanto ICE Processing Center West is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2017 Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

The inspection team identified one (1) deficient component in the following one (1) standard:

Funds and Personal Property- 1, which is a repeat deficiency

Facility Snapshot/Description

The Adelanto ICE Processing Center West is owned and operated by the GEO Group, Inc. (GEO) and is located in a commercial district of southwestern Adelanto, CA, a high desert region. The current ICE contract was promulgated between ICE and the City of Adelanto. GEO is the sub-contractor for the City. The one-story direct-supervision facility houses adult male detainees of all classification levels. Female detainees are not housed at this facility except when severe mental illness requires temporary segregated housing for a female from the adjacent facility. During the inspection, the total count was 1198. The average length of stay for an ICE detainee is 70 days.

The housing units consist of upper and lower ranges of cells in every housing unit. There are four general population housing units, each containing four 80-person cellblocks. There are also two segregation cellblocks. The housing units have spacious dayrooms and the cell doors are never locked, except in the segregation areas. Every unit has two televisions, telephone banks and various board games. Each housing unit is equipped with two kiosks programmed with LexisNexis which are available to detainees 24 hours a day, seven days a week. There is one outdoor recreation area for every two cellblocks. There is also a large centralized outdoor recreation yard in which all detainees are offered recreation at least one hour per day. The atmosphere throughout the housing units was relaxed. Detainees interacted with staff and each other without hesitation or noticeable anxiety. Detainees were forthcoming in interviews with the inspection team. No common complaints were noted. Without exception, detainees stated that they felt safe at this facility and knew how to contact ICE officers if they had questions or concerns.

The staff were professional and displayed a clear understanding of the concept of civil detention and the PBNDS 2011 Standards. Many of the staff are bilingual. Interviews with LEP detainees indicated that they had no issues communicating with staff and no problems obtaining services. Confidential interviews revealed no concerns. The inspection team interviewed no less than 105 detainees during the inspection.

Medical services are provided by Correct Care Solutions. All other services are provided by the GEO Group employees. There is no medical co-pay.

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Areas of Concern/Significant Observations

There were no concerns or significant observations

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector October 5, 2017

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

October 11, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Adelanto ICE Processing Center West**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Adelanto ICE Processing Center West in Adelanto, California during the period of October 9-11, 2018. This is a DIGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility was rated as Meets Standards during the October 2017 inspection.

Inspection Summary

The Adelanto ICE Processing Center West is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 annual compliance inspections:

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2017 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

The inspection team identified one (1) deficient component in the following one (1) standard:

Funds and Personal Property- 1, which is a repeat deficiency

Facility Snapshot/Description

The Adelanto ICE Processing Center West is owned and operated by The GEO Group, Inc. (GEO) and is located in a commercial district of southwestern Adelanto, California, a high desert region. The current ICE contract was promulgated between ICE and the City of Adelanto. GEO is the sub-contractor for the City. The one-story direct supervision facility houses adult male detainees of all classification levels. The facility is a Dedicated IGSA facility. During the first day of the inspection, the count on was 1204. The average length of stay for an ICE detainee is 72 days.

The physical plant includes visitor and reception areas, five court rooms, indoor and outdoor recreation, an artificial soccer field and a 112-bed special management unit. The building is air-conditioned. The housing units consist of upper and lower ranges of cells in every housing unit. The facility is made up of sixteen (16) dormitory style housing units equipped with eighty beds each. There are also two segregation cellblocks. The housing units have spacious dayrooms. Cell doors are never locked, except in the segregation areas. Every unit includes two televisions, telephone banks and various board games. Each housing unit is equipped with two kiosks programmed with LexisNexis which are available to detainees 24 hours a day, seven days a week. There is one outdoor recreation area for every two cellblocks. There is also a large centralized outdoor recreation yard in which all detainees are offered recreation at least one hour per day. Detainees have access to movies and x-box games in each day room. The atmosphere throughout the housing units was relaxed. Detainee visitation is offered seven days per week. Detainee programs include religious services, 12-step addiction/recovery, anger management, mindfulness, self-esteem and positive coping skills. Detainees interacted with staff and each other without hesitation. Detainees were forthcoming in interviews with the inspection team. No common complaints were noted. Without exception, detainees stated that they felt safe at this facility and knew how to contact ICE officers if they had questions or concerns. There were no complaints about food, telephone access, or recreation. None of the detainees voiced any concerns relative to their care and treatment while being housed in the SMU. A couple of detainees voiced complaints about officers being disrespectful. This complaint was reported to the chief of security who stated supervisory staff was already aware of this and monitoring the situation. Ten detainees were interviewed by the medical SME. There was one complaint. The detainee complained that he was not receiving appropriate medication for his condition and that he could not understand the medical provider. Further review of this detainee's medical record confirmed that he was seen by a medical provider who was fluent in Spanish. The medical record confirmed that the detainee was treated according to medical protocol.

The staff was professional and displayed a clear understanding of the concept of civil detention and the PBNDS 2011 Standards. Many of the staff are bilingual. Interviews with LEP detainees indicated that they had no issues communicating with staff and no problems obtaining services. Confidential interviews revealed no concerns. The inspection team interviewed no less than 125 detainees during the inspection.

Medical services are provided by Correct Care Solutions. All other services are provided by The GEO Group, Inc. employees. Detainees are not charged a co-payment for medical or mental health services.

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Areas of Concern/Significant Observations

The recent OIG report indicated that a detainee had been confined to a wheelchair for nine days without moving from the chair. A medical record review and interviews with staff and the detainee during this annual inspection revealed that the detainee is in fact not confined to a wheelchair, but was rather issued a wheelchair out of courtesy so that he could sit in his cell and watch television. Segregation records indicate that, during the nine days cited on the OIG report as the detainee having no movement, he in fact was walking, standing, eating, and lying on his bed. He was clearly not in the wheelchair for nine consecutive days with no movement, as reported by OIG. This fact was easily documented via records review. Although the detainee is legally blind, he could make out enough images to enjoy television viewing, and the facility made the decision to give him a wheelchair to sit in while watching television, for his convenience. All of these facts were readily available, but it seems that the OIG inspection team chose not to check them or include them in their report. ICE and facility staff also reported that an OIG inspector spent two hours trying to talk the same detainee into another housing assignment, to no avail. The detainee ultimately dismissed the OIG inspector so that he could return to his personal recreation in his cell. There was apparently no thought given by the OIG inspector to the possibility that the detainee preferred his living arrangement to others offered throughout the facility, as records indicate that the detainee had been housed in a number of settings throughout the facility, including the medical area, general population housing, disciplinary housing, and administrative segregation housing. The onsite staff question the appropriateness of an OIG inspector involving themselves in the counseling or daily management of detainees at the facility; an excellent question in the view of the annual inspection team.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — October 11, 2018

Printed Name of LCI — Date

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001550
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The Nakamoto Group, Inc.

November 21, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Adelanto ICE Processing Center East**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the Adelanto ICE Processing Center East in Adelanto, California, during the period of November 19-21, 2019. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the October 2018 inspection.

Inspection Summary

The Adelanto Ice Processing Center East is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual compliance inspections:

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2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standard	0
Repeat Deficiency	0
Not Applicable	2

2019 Annual Inspection	
Meets Standards	40
Does Not Meet Standard	0
Repeat Deficiency	0
Not Applicable	2

The inspection team identified six (6) deficient components in the following three (3) standards:

Classification System - 1
Medical Care - 2
Terminal Illness, Advance Directives, and Death - 3

Facility Snapshot/Description

The Adelanto ICE Processing Center East is located in the desert southwest region of Adelanto, California, neighboring other correctional facilities and government buildings. The facility is owned and operated by the GEO Group, Inc. The facility is a Dedicated IGSA facility housing male and female detainees of all classification levels. On the first day of the inspection the total population at the facility was 479; with 210 male and 269 female detainees. The average length of stay is 75 days.

(b)(7)(E)

(b)(7)(E) Dayroom areas provide adequate open space and sedentary activities such as television viewing and board games. Telephones are provided in the housing units and are available to detainees 24 hours a day. There are also two computer kiosks providing access to LexisNexis in each housing unit. Outdoor recreation is available seven days a week. Sanitation was observed to be average with some clutter noted in the sleeping areas. Detainees interviewed during the inspection voiced few complaints regarding sanitation. Two female detainees complained of mold in housing unit D-1. One of the detainees pointed out an area on a back wall underneath a bunk that had a black discoloration on the wall and baseboard that may be mold. The other detainee stated that there was mold underneath the bench in one of the showers. Some soap scum was noted; however, there did not appear to be any mold. These areas were pointed out to facility staff. It was also noted that the heating vents and ceiling in the upper level sleeping area was in need of cleaning.

A male detainee approached an inspector with a litany of complaints about his treatment by officers and the lack of medical care for his high blood pressure. Investigation of his complaints found that he had been moved from the West facility because he was continually late when detainees from his housing unit were taken to the dining room for meals resulting in him missing meals from time to time. He was moved to the East facility where the meals are served in the housing units and he won't miss any meals. The Medical SME reviewed his medical chart and found that he has been seen by medical staff regularly and his blood pressure is being monitored. The detainee also stated that he had been on a hunger strike but when questioned further he admitted that he had only refused a couple of meals and never declared a hunger strike.

A female detainee stated that she has sent numerous requests to her ICE officer and has not received a response to these requests. A review of the request log and copies of the requests from the detainee indicated that her requests have all been responded to in a timely manner by the officer. The detainee also stated that she had suffered a concussion and had received no follow-up treatment. A review of her medical records indicated that she had been injured when another detainee fell on her while climbing up to the bunk above her. She was treated at the time of the accident and has been seen several times for ongoing complaints. She has been seen by a neurologist. Another female detainee complained about the lack of medical care. A review of her medical record indicated that she has been seen numerous times by medical staff and all of her complaints have been addressed.

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The telephonic translation line was used to conduct interviews of LEP detainees from Mexico and China. All of the detainees stated they felt safe at the facility. None of the detainees expressed any concerns about the facility. Several detainees from China informed inspectors that they had been unable to call their families. It was determined that the telephone provider (TALTON) is in negotiations with China to permit detainee calls. Facility staff stated that the detainees would be permitted to attempt to contact their families using a facility telephone.

The inspection team visited the housing units several times during the inspection to conduct group and confidential interviews. The atmosphere was relaxed and detainees were observed interacting with facility staff and other detainees. They approached the inspection team without hesitation. No detainees expressed any concerns about their safety. There were no concerns regarding the law library or recreation. Detainees were aware of the procedures to request health care.

Medical services are provided by WellPath. All other services are provided by the GEO Group, Inc. Detainees are not charged a co-payment for medical or mental health services.

Areas of Concern/Significant Observations

The facility achieves optimal compliance with a number of standard requirements such as telephone ratios, law library access, and outdoor recreation.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS 2011). No (0) standards were found Does Not Meet Standard and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Lead Compliance Inspector — November 21, 2019

Printed Name of LCI — Date

AMERICAN OVERSIGHT

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The Nakamoto Group, Inc.

November 21, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Adelanto ICE Processing Center West**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Adelanto ICE Processing Center West in Adelanto, California during the period of November 19-21, 2019. This is a DIGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C), Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the October 2018 annual inspection.

Inspection Summary

The Adelanto ICE Processing Center West is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS annual compliance inspections:

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2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	2

2019 Annual Inspection	
Meets Standards	39
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	3

The inspection team identified seven (7) deficient components in the following three (3) standards:

Classification System- 1
Medical Care- 2
Terminal Illness, Advance Directives, and Death- 4

Facility Snapshot/Description

The Adelanto ICE Processing Center West is located in the high desert southwest region of Adelanto, California, neighboring other correctional facilities and government buildings. The facility is owned and operated by the Geo Group, Inc.; as is the adjacent facility, Adelanto ICE Processing Center East. The Geo Group has an intergovernmental services agreement with ICE and the City of Adelanto, California. The facility is a Dedicated IGSA housing male ICE detainees of all classification levels under the direct supervision model. During the inspection the count was 1,037. The average length of stay is 63 days.

Detainees are housed in sixteen cellblocks in two- or four-person cells situated on upper and lower ranges in each housing unit. There is a segregation unit as well. The entire building is air-conditioned. The housing units have dayrooms with televisions, video games, board games, and telephones. Attached to each unit is an outdoor recreation area which detainees may use up to six hours per day, seven days per week, resulting in optimal compliance for the outdoor recreation requirements. Detainees are offered additional recreation on a large centralized outdoor recreation yard for at least one hour per day. Each housing unit is equipped with two kiosk computers loaded with the LexisNexis program available to detainees every day during waking hours as well as two stand-alone law libraries providing optimal compliance in regards to access to legal services.

The atmosphere was relaxed throughout the facility and detainees were observed interacting with one another and recreating for the most part. Staff and detainees interact informally and without apparent hesitation. Staff are professional in appearance and tend to be informed regarding the standards as related to their individual duties. A significant percentage of the staff are bilingual.

The inspection team conducted no less than eighty detainee interviews; 23 of which were formal interviews. One detainee stated that an officer had made a sarcastic comment to him. He did not file a complaint or a grievance. The inspector suggested that he do so if he wanted the complaint investigated. Five detainees complained that they did not like the food and one detainee stated that the meal portions were too small; yet another did not like the menu variety. The Safety SME confirmed that the menu was approved by a dietician; that the serving size of food portions met the minimum daily requirements; and that the menu had sufficient variety for the demographics of the detainee population. One detainee stated that there were ventilation problems and a lack of air conditioning in the housing units. The Safety SME confirmed that the ambient temperatures in the housing units were within the guidelines of the standards. One detainee complained of mold in the showers. Every shower in the facility was inspected and one individual shower had a small patch of mildew on the ceiling; and upon notification of the findings, the facility took immediate action to eradicate the mildew. One detainee complained that an x-ray was overdue. The Medical SME checked and determined that the medical department had not ordered the x-ray as intended; the facility then scheduled the x-ray for the next day. Three detainees complained of miscellaneous medical issues and all were under current, active care of the health services department with their conditions being addressed. Without exception, detainees stated that they felt safe at this facility and

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knew how to contact ICE officers if they had questions or concerns. Interviews with LEP detainees indicated that they had no problem obtaining services. Confidential interviews revealed no concerns.

Medical services are provided by Wellpath. All other services are provided by the GEO Group, Inc. Detainees are not charged a co-payment for medical or mental health services.

Areas of Concern/Significant Observations

Of significance is that the facility achieves optimal compliance with a number of standards' requirements such as telephone ratios, law library access, and outdoor recreation opportunities.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and three (3) standards were Not Applicable (N/A). The remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden James Janecka, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	November 21, 2019
Printed Name of LCI		Date

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001556
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The Nakamoto Group, Inc.

March 30, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the Cibola County Correctional Center**

The Nakamoto Group, Inc. performed an annual/90 day follow-up inspection for compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011 of the Cibalo County Correctional Center in Milan, New Mexico during the period of March 28-30, 2017. This is an IGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Security	(b)(6); (b)(7)(C)	
Detainee Rights		
Medical Care		
Safety		
QMC		

Type of Inspection

This is a scheduled annual/90 day follow-up inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities.

Inspection Summary

The Cibola County Correctional Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – No
- The Joint Commission (TJC) – Yes
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 pre-occupancy and 2017 PBNDS 2011 annual compliance inspections:

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2016 Pre-Occupancy Inspection	
Meets Standards	40
Deficient	0
At-Risk	0
Repeat Deficiency	0
Not Applicable	2

2017 Annual Inspection	
Meets Standards	40
Deficient	0
At-Risk	0
Repeat Deficiency	0
Not Applicable	2

Facility Snapshot/Description

The Cibola County Correctional Center is owned and operated by CoreCivic, formerly known as Corrections Corporation of America. (b)(7)(E)
(b)(7)(E)
(b)(7)(E) The facility is located in the city of Milan, New Mexico, near Interstate 40. The facility houses only male ICE detainees. The facility capacity is 1204. The population count on the first day of the inspection was 581 ICE detainees. The average length of stay for an ICE detainee is 28 days.

Detainees are housed in various sized dormitories, ranging from eight to forty-eight beds. There are a total of thirty-three housing pods. The segregation area is single-celled. Each dormitory has a dayroom area with ample tables, chairs, television viewing space, telephones, showers and wash basins. Cards and board games are also available There are two large outdoor recreation yards and a spacious gymnasium for detainee use.

A majority of facility staff are bilingual; possibly even all of them, as the inspection team did not encounter any staff that was not. Staff members are aware of their responsibilities and the rights afforded the detainees, as applicable to the standards. Staff enthusiastically took ownership of their individual areas. However, the setting is that of a typical jail, making the concepts of civil detention difficult to incorporate into the daily operations.

The environment is calm and without obvious tension. Detainees were observed interacting with themselves and staff without hesitation or apparent fear. Interviews with detainees of Limited English Proficiency revealed no issues with them obtaining services or understanding their environment. Confidential interviews gave no indication of fear or mistrust of staff. Detainee interviews were void of any complaints, and in fact were complimentary about both the quality and quantity meals served, the medical dare, and the treatment they received from the facility staff. ICE officers engage detainees frequently, and the inspection team received no questions or complaints about ICE-related issues, such as court dates, asylum requests, etc., as is the norm at most facilities. The inspection team interviewed no less than 75 detainees.

Food service is contracted through and provided by Trinity Services Group. Medical services are provided by Correct Care Solutions. All other services are provided by CoreCivic.

Areas of Concern/Significant Observations

Of significance is the fact there were no deficient components identified during this inspection.

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Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Brian Koehn, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — March 30, 2017

Printed Name of LCI — Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

May 10, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Cibola County Correctional Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Cibola County Correctional Center in Milan, NM during the period of May 8-10, 2018. This is an IGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a rating of Meets Standards during the March 2017 inspection.

Inspection Summary

The Cibola County Correctional Center is currently accredited by:

- The American Correctional Association (ACA) – No
- The National Commission on Correctional Health Care (NCCHC) – No
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2017 Inspection	
Meets Standards	40
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	2

2018 Inspection	
Meets Standards	40
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	2

The inspection team identified five (5) deficient components in the following four (4) standards:

Environmental Health and Safety – 1
Hold Rooms in Detention Facilities – 2, both are priority components
Staff-Detainee Communication – 1
Use of Force and Restraints – 1, which is a priority component

Facility Snapshot/Description

The Cibola County Correctional Center is owned and operated by CoreCivic. The facility is located in the city of Milan, New Mexico, near Interstate 40. The 1,204-bed facility houses male and female detainees for the U.S. Marshals and local jurisdictions and male ICE detainees. The facility also houses transgender ICE detainees who are biologically male and self-identify as female. These detainees are housed in a separate housing unit away from other detainees. The count on May 8, 2018 was 982 with 332 ICE detainees. Thirty-two of the ICE detainees were transgender. The average length of stay for most ICE detainees was reported to be 25 days. The average length of stay for a transgender ICE detainee is 81 days.

The inspection team visited all ICE detainee housing units several times during the inspection. It was noted that the facility is clean and in good repair. Detainees were interviewed in all housing units. Detainees were complimentary of staff interactions noting that staff is respectful and professional. All detainees interviewed stated that they did not fear for their safety and noted that there is a low level of violence at the facility. Detainees were observed playing board games and socializing with other detainees. Televisions, telephones, microwaves, video games and movies are available in the housing units. An inspection of the transgender unit revealed that detainees may participate in gardening programs and English as a Second Language classes.

There were no substantive complaints regarding food or access to telephones. Four detainees voiced concerns regarding timely follow-up of sick call requests. The review of the medical records for each detainee did not show any delay in evaluation, examination or treatment. Interviews with transgender detainees elicited no concerns regarding access to health care or privacy.

Several detainees complained of the lack of daily outdoor recreation time. A review of housing unit logs revealed that detainees are offered one hour and fifteen minutes of outside recreation each day which exceeds the requirement of the standard. Outdoor recreational activities include basketball, soccer, volleyball, jogging and intramural games between housing areas.

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Individual libraries containing pleasure reading books and LexisNexis computers are located inside each detainee living unit for easy access. Detainees have access to the library, upon request, during facility waking hours.

Medical services are provided by Correct Care Solutions (CCS). Detainees are not charged medical, dental or mental health copay fees.

Areas of Concern/Significant Observations

Hold Rooms in Detention Facilities:

Priority Component #4: Detainees are not held in hold rooms for more than twelve hours.

Finding:

A random review was conducted to determine the amount of time detainees were held in hold rooms during the inspection period. The review determined that more than 50% of the detainees were held longer than twelve hours.

Recommendation:

(b)(5)

Priority Component #1: Officers closely supervise hold rooms through direct supervision to ensure;

- Continuous auditory monitoring
- Visual monitoring at irregular intervals at least every 15 minutes
- Constant surveillance of any detainee exhibiting signs of hostility, depression, or similar behaviors

Finding:

Documentation of visual monitoring of ICE detainees being held in hold rooms, revealed that visual monitoring was being conducted every thirty minutes instead of every fifteen minutes as required by the standard.

Recommendation:

(b)(5)

Use of Force and Restraints:

Priority Component #11: All use of force incidents are documented and reviewed. Staff prepare a use of force form that identifies the detainee(s), staff, and others involved, describes the incident, and documents the location of strikes if intermediate force weapons are used. All calculated use of force incidents are properly audio-visually documented and forwarded for review. Use of force documentation at a minimum, shall include the

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medical examination through the conclusion of the incident. All calculated use of force incidents must be audio-visually recorded in its entirety from the beginning of the incident to its conclusion.

Finding:

There were four use of force incidents involving ICE detainees during this inspection period. Two of the four were calculated uses of force. It was observed that the after-action review date for three of the incidents was sixty days or more past the incident date. The after-action review procedure approved by ICE/ERO and outlined in the facility's incident reporting policy 5-1, requires that after-action reviews of use of force incidents convene on the workday after the incident.

Recommendation:

(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were rated Does Not Meet Standards, two (2) standards were non-applicable (N/A). The remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Brian Koehn, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Lead Compliance Inspector — May 10, 2018

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

May 9, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Cibola County Correctional Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the Cibola County Correctional Center in Milan, NM, during the period of May 7-9, 2019. This is an IGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the May 2018 annual inspection.

Inspection Summary

The Cibola County Correctional Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) - No
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and the 2019 PBNDS 2011 annual inspections:

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2018 Annual Inspection	
Meets Standard	40
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	2

2019 Annual Inspection	
Meets Standard	40
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	2

The inspection team identified four (4) deficient components in the following four (4) standards:

Admission and Release—1
Correspondence and Other Mail—1
Grievance System—1
Detention Files—1

Facility Snapshot/Description

The Cibola County Correctional Center is located in Milan, NM, 87 miles west of the Albuquerque International Sunport Airport, Albuquerque, NM. The facility, constructed in 1994 and renovated in 2000, is owned and operated by CoreCivic, a private prison corporation headquartered in Nashville, TN. CoreCivic operates the facility pursuant to a contract with Cibola County which has an IGSA with the United States Department of Homeland Security ICE. The facility has a rated capacity of 1204 beds and an operational capacity of 1116 beds. Low and medium-low custody adult male ICE detainees and all custody levels of transgender ICE detainees, male and female U.S. Marshals Service prisoners and male and female county inmates are housed at the facility. On the first day of the inspection the population count was 882 of which 356 were ICE detainees. The average daily population for ICE for the previous twelve months was 328.62 with an average length of stay of 25.7 days.

The facility is a one-story structure which contains nine detainee housing units, administrative offices, the medical department and various programmatic and service areas. The housing units consist of either one or two tiers and several housing pods within each housing unit. During the inspection, four housing units were occupied by ICE detainees. The ICE detainee general population housing pods range in capacities from 38 to 60 beds. Both cell and dormitory housing is available. (b)(7)(E)
(b)(7)(E)
(b)(7)(E) A restrictive housing unit is available for administrative and disciplinary segregation housing. ICE detainees are not commingled with non-ICE detainees.

(b)(7)(E)

The facility provides both indoor and outdoor recreation areas. Detainees in the general population are offered either indoor or outdoor recreation two hours per day, seven days per week. Housing areas provide dayroom space, adequate restroom facilities and seating areas for their maximum occupancy. Televisions, playing cards, board games, kiosks for purchasing commissary items and a microwave oven are available in the dayrooms.

The entire facility is climate controlled. Cleanliness and sanitation throughout the facility were observed to be average with the exception of the restricted housing unit which was observed to be above average.

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All housing units and common areas of the facility were visited and/or observed during the inspection with the exception of two housing units which were under cohort (quarantine); 32 detainees for varicella (chickenpox) and 29 for mumps. The inspection team members did not enter the cohort housing units and the medical authorities disapproved the LCI's request to escort detainees from those housing units to a private room for interviews. The 29 detainees under cohort for mumps were identified as transgender.

Numerous detainees were interviewed; some interviews were in housing units or work areas with small groups of detainees and several were private and confidential and included detainees with limited English proficiency (LEP). Interviews included detainees who had recently arrived at the facility and some who had been housed at the facility for longer periods of time. The detainees voiced no concerns regarding life/safety issues. Detainees stated they felt safe and were generally satisfied with the interaction, responsiveness and professionalism of facility and ICE staff and with access to medical services, mail, the law library, telephones, visitation and recreation. Detainees expressed general satisfaction with the quantity and quality of food provided.

Detainee telephone services are provided via the ICE contract with Talton Communications, Inc.; medical services are provided by Wellpath; and food service operations are contracted with Trinity Services Group. All other services are provided by CoreCivic. ICE detainees do not incur medical co-pays.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — May 9, 2019

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

September 28, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the Denver Contract Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Denver Contract Detention Facility in Aurora, CO during the period of September 26-28, 2017. This is a CDF.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the September 2016 inspection.

Inspection Summary

The Denver Contract Detention Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2017 Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

Facility Snapshot/Description

The Denver Contract Detention Facility is a 1,108 bed facility operated by GEO Group, Inc. It currently houses male and female ICE detainees and male U.S. Marshals detainees. The facility is a single structure one-story building which opened in 1987. (b)(7)(E) (b)(7)(E) The facility perimeter is comprised of exterior walls of building; (b)(7)(E) (b)(7)(E) (b)(7)(E) The facility is located in Aurora, Colorado approximately fifteen miles west of Denver, Colorado. The average daily population of the facility during the inspection period was 689, of which 611 were ICE detainees. The average length of stay for an ICE detainee is 45 days.

The facility has thirteen different general population detainee housing units ranging from four man cells to a 48 bed dormitory. There are two separate 48-cell segregation units; they are referred to as restricted housing units (RHU). All RHU cells are single man occupancy. ICE detainees can be housed in any of the housing units based on their classification score. The day rooms are furnished with a television, telephones, tables and open space. Each detainee has a lockable personal property storage bin. Indoor and outdoor recreation is made available to all populations for at least one hour a day, seven days a week. The outdoor recreational yards have accessible water and toilet facilities. The RHU has its own outdoor recreation area.

ICE maintains an on-site presence in the facility. ICE personnel were seen talking with detainees throughout the facility during the entire inspection. The atmosphere in the housing units was relaxed and detainees openly communicated with the inspection team. Facility employees are experienced and very knowledgeable of the ICE standards, their demands and the duties of their posts. Staff interaction with detainees was direct, respectful and responsive to their requests. Detainees were orderly in their daily movements, housing unit behaviors and program/activity participation. The inspection team interviewed 72 LEP and English speaking detainees publicly and privately in the housing unit and in the common areas. They registered no substantive complaints or concerns when questioned about personal safety, treatment by staff, medical care, asylum requests, consulate/court access, ICE availability, telephone access, visiting privileges, law library access or food services.

Medical and food services are provided by GEO Management & Training Corporation. The facility is well maintained and represents above average sanitation.

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Areas of Concern/Significant Observations

There were no deficient components identified during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C) from the Denver Field Office
- Facility Staff – Warden Johnny Choate (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector September 28, 2017

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

October 4, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the Aurora ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Aurora ICE Processing Center (formerly Denver CDF) in Aurora, Colorado during the period of October 2-4, 2018. This is a CDF.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the September 2017 inspection.

Inspection Summary

The Aurora ICE Processing Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified three (3) deficient components in the following three (3) standards:

Hold Rooms in Detention Facilities – 1, which is a Priority component
Special Management Units – 1, which is a Priority component
Grievance System - 1

Facility Snapshot/Description

The Aurora ICE Processing Center (formerly Denver CDF) is a 1108 bed facility operated by The GEO Group, Inc. (GEO). The facility currently houses male and female ICE detainees and male U.S. Marshals Service detainees. The facility is a single structure one-story building. (b)(7)(E)

(b)(7)(E)

(b)(7)(E) The facility is located in Aurora, Colorado, approximately fifteen miles west of Denver, Colorado. The population of the facility on the first day of the inspection was 951, of which 891 were ICE detainees (811 males and 80 females). Male detainees are classified low, medium low, medium high and high. Female detainees are classified low, medium low and medium high. The average length of stay for an ICE detainee was reported as 46 days.

The facility has thirteen different general population detainee housing pods ranging from four-person cells to 48-bed dormitories. There are two 48-cell segregation pods, referred to as restricted housing units (RHU). All RHU cells are single occupancy. ICE detainees are not commingled with U.S. Marshal detainees. Day rooms are furnished with a multipurpose room, television, telephones, tables and a day room. Electronic tablets are available in each housing unit. The tablets include the following information: detainee request forms, text message function, law library, detainee handbooks, religious material, video visitation, audio books, E-books, games, movies, television shows, music education materials, calculator, dictionary, news, meditation and sports. The tablets supplement the programs and services provided at the facility. Detainees stated, in summary, "that the tablets are readily available and there is rarely a waiting list to use a tablet". Each detainee has a lockable personal property storage bin. Indoor and outdoor recreation is provided at least one hour a day, seven days a week. The outdoor recreational yards have accessible water and toilet facilities. Each housing unit is equipped with an outdoor recreation area.

During the inspection, there was one active case of chicken pox, and the detainee was housed in isolation in the medical department. The detainee's housing pod was quarantined for twenty-one days in order to monitor for additional cases. The HSA had written documentation of her email notice to the field office.

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ICE maintains an on-site presence in the facility. ICE personnel were seen talking with detainees during the inspection. The atmosphere in the housing units was relaxed and detainees openly communicated with the inspection team. Facility employees are experienced and very knowledgeable of the ICE standards, their demands and the duties of their posts. Staff interaction with detainees was direct, respectful and responsive to their requests. Detainees were orderly in their daily movements, housing unit behaviors and program/activity participation. The inspection team interviewed no less than 85 detainees. Confidential and LEP interviews were conducted. Interviews were conducted in the special management unit, kitchen, law library, dayrooms, recreation and visiting rooms. Detainees voiced no concerns regarding safety, conditions of confinement, treatment by staff, asylum requests, consulate/court access, ICE availability, telephone access, visiting privileges, law library access or food services. None expressed any concerns about their treatment and all stated they felt safe at the facility. Everyone stated they were treated respectfully by security officers. Two detainees expressed concerns regarding the treatment they were receiving for specific medical issues. These concerns were conveyed to the medical SME for follow-up. As a result of the follow up, one of the detainees was seen by medical staff and evaluated. The second detainee's medical issue requires that he be seen by a specialist at a local hospital. This requires ICE field office approval which was still pending during the inspection. The medical SME addressed this issue with the HSA who stated she would follow up with an ICE official. The SDDO was advised during the inspection. Cleanliness inside the facility was viewed as above average.

Medical and food services are provided by The GEO Group, Inc. Detainees are not charged a co-payment for medical services.

Areas of Concern/Significant Observations

There were two Priority Components rated Does Not Meet Standard:

Hold Rooms in Detention Facilities

Component #4 – Detainees are not held in hold rooms for more than twelve hours.

Findings: A review of detention intake logs revealed that intake officers had failed to enter either the time a detainee was placed in a hold room or the time a detainee was released from a hold room. Documentation was not available to determine whether or not the twelve-hour limit for holding a detainee in a hold room was within standard guidelines.

Recommendation: (b)(5)
(b)(5)

Special Management Units

Component #18 – Health care personnel conduct face-to-face medical assessments for every detainee in an SMU at least once daily.

Findings: Observation of the mid-morning medication pass conducted by medical personnel revealed that not all detainees were being seen by the medical staff. Interviews conducted with the medical staff, SMU officer and SMU detainees confirmed that all detainees (in SMU) are not being seen on a daily basis. Only detainees requiring medication are being seen.

Recommendation: (b)(5)
(b)(5)

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Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — October 4, 2018

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

November 27, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the Aurora ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Aurora ICE Processing Center (formerly Denver CDF) in Aurora, Colorado during the period of November 25-27, 2019. This is a CDF.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72-hour facilities. The facility received a previous rating of Meets Standards during the October 2018 inspection.

Inspection Summary

The Aurora ICE Processing Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 annual compliance inspections:

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2018 Annual Inspection	
Meets Standard	41
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	1

2019 Annual Inspection	
Meets Standard	41
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	1

The inspection team identified five (5) deficient components in the following three (3) standards:

Hold Rooms – 1
Significant Self-Harm and Suicide Prevention and Intervention – 1, which is a priority component
Grievance System – 3, two of which are priority components

Facility Snapshot/Description

The Aurora ICE Processing Center is located in Aurora, CO, which is approximately ten mile east of Denver, CO. The facility is owned and operated by The GEO Group, Inc., a private corrections company. It is a CDF which currently houses adult male and female ICE detainees of all custody levels and adult male U.S. Marshals detainees. ICE/ERO maintains an on-site presence Monday through Friday. The facility is composed of two units; the main unit, in which most of the support services are delivered; and the annex which provides additional housing and some duplicate support services from the main unit. The facility has a rated capacity of 1,304. The average daily population of the entire facility during the inspection was 934 detainees, of which 878 were ICE detainees; 611 in the main unit and 267 in the annex. The average length of stay for a detainee is 55 days.

The facility opened in 1987 and expanded to its current size in 2019. The compound consists of two distinct sections inside the fence; the main facility (North) and the annex (South). Many of the support services are shared. Travel between the two buildings is frequent. (b)(7)(E)

(b)(7)(E)

All general population detainees are housed in five separate housing units, each with various sections ranging in configuration of eight to sixty bed dormitories and four to eight bed cells. There is one ICE/ERO special management unit (referred to as restricted housing unit at this facility) consisting of 48 one-bed cells. All main housing units are managed under direct supervision. Annex housing units are supervised by assigned roving officers.

Each housing unit has a dayroom equipped with three televisions, fixed dining/seating tables where detainees can play board games, cards, engage in social interactions with one another and watch television, and electronic tablets on which detainees can order commissary, participate in video-visits, watch movies, send e-mails and play games. Each housing unit has a kiosk on which detainees can place their weekly commissary orders.

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.
Each detainee has a lockable personal property storage bin. All detainees have access to indoor and outdoor recreation. There are nine outdoor recreational yards. Outdoor recreation is provided at least one hour a day, seven days a week for all detainees. Detainees have access to water and toilet access when using the yard.

Several detainees were interviewed throughout the inspection using the language line and a bi-lingual inspector. Interviews were with detainees of various custody levels from different housing units. The interviews took place in a private setting. Detainees had no reservations about speaking with their interviewers. Overall, the detainees voiced no substantive complaints or concerns when questioned about their personal safety, treatment by staff, conditions of confinement, medical care, asylum requests, consulate/court access, ICE/ERO services, visiting privileges, law library access, food services or recreational opportunities. One Nigerian detainee was unhappy with the food selections as it did not reflect the dietary customs of his home land. The food service SME discussed the concern with the food service manager. The cycle menu is adequate and reflects many different ethnic cuisines, just not his. There were two minor medical concerns raised by two different detainees. Both concerns were discussed with health care staff by the medical SME. The first issue concerned a vision problem. It was determined the detainee has extremely poor vision. The detainee has requested his family to send in his special eyeglasses, they have not yet been received. Upon receipt and a subsequent security clearance, they will be issued. The second issue was a detainee receiving the results of his September 23, 2019 MRI. Health care staff have made frequent requests to the provider but the results have not yet been forwarded. In both instances, the concerns were previously addressed; proper protocols are being followed. Both detainee concerns will be satisfied upon receipt of the requested article/test results.

Cleanliness inside the facility is considered to be above average.

All security and support services are provided by The GEO Group, Inc. employees. Detainees are not charged a co-payment for medical services.

Areas of Concern/Significant Observations

There were three priority components rated Does Not Meet Standard:

4.6 Significant Self-Harm and Suicide Prevention and Intervention:

Component #6: PRIORITY: Suicidal detainees should be closely supervised in a setting that minimizes opportunities for self-harm. The isolation room designed for evaluation and treatment must be free of objects or structural elements that could facilitate a suicide attempt, and security staff shall ensure that the area for suicide observation is initially inspected so that there are no objects that pose a threat to the detainee's safety. A suicidal detainee may be placed in the Special Management Unit only if space has been approved for this purpose by medical staff and such space allows for unobstructed observation.

Finding: The suicide precautions/watch rooms are free of objects which may facilitate a suicide attempt. However, one of the two rooms (#535) has a floor to ceiling wall which completely obscures the view of the officer while the detainee is in that area.

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Recommendation: (b)(5)

(b)(5)

6.2 Grievance System:

Component #6: PRIORITY: Each facility shall have written policy and procedures for a detainee grievance system that:

- Establishes a procedure for any detainee to file a formal grievance;
- Establishes a procedure to track or log all ICE detainee grievances separately from other facility populations;
- Establishes reasonable time limits for:
  Processing, investigating, and responding to grievances;
  Convening a grievance committee (or actions of a single designated grievance officer) to review formal complaints; and
  Providing written responses to detainees who filed formal grievances, including the basis for the decision.
- Ensures a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable;
- Establishes a special procedure for time-sensitive, emergency grievances, including having a mechanism by which emergency medical grievances are screened as soon as practicable by appropriate personnel;
- Ensures each grievance receives appropriate review;
- Provides at least one independent appeal that excludes individuals previously involved in the decision-making process for the same grievance;
  Includes guarantees against reprisal; and
- Ensures information, advice, and directions are provided to detainees in a language or manner they can understand, or interpretation/translation services are utilized.

Finding: The facility has written policy and procedures for a detainee grievance system. A review of documentation revealed: medical grievances are not being logged or tracked consistently; a high number of medical grievances were not accounted for on a grievance log; responses to medical grievances are not consistently made within five working days; there is no mechanism in place in which emergency medical grievances are screened as soon as practicable; and the medical grievance system does not provide at least one independent appeal that excludes the individual involved in the decision making process for the same grievance.

Recommendation: (b)(5)

(b)(5)

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Component #11: PRIORITY: Each facility shall maintain a Detainee Grievance Log. The documentation shall include: the date the grievance was filed, the name of the detainee that filed the grievance, the nature of the grievance, the date the decision was provided to the detainee, and the outcome of the adjudication.

A copy of the grievance disposition shall be placed in the detainee's detention file and provided to the detainee. Medical grievances are maintained in the detainee's medical file.

Findings: The facility has written policy and procedures regarding maintaining detainee grievance logs. The facility uses a computerized system (GEOTrack) for entering all grievances. A review of the non-medical grievance log reveals that the entries did not consistently include the date the grievance was filed, the name of the grievant, along with the nature of the grievance, the date the decision was provided to the detainee nor the outcome of the adjudication.

Recommendations: (b)(5)

(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C) personnel
- Facility Staff – Warden J. Choate, (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector November 27, 2019

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 26, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Imperial Regional Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Imperial Regional Detention Facility Center in Calexico, CA during the period of January 24-26, 2017. This is a dedicated IGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2016 inspection.

Inspection Summary

The Imperial Regional Detention Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – No
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	41
Deficient	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Deficient	0
Repeat Finding	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following one (1) standard:

Staff-Detainee Communication - 1

Facility Snapshot/Description

The Imperial Regional Detention Facility is managed by Management and Training Corporation (MTC) and is located in the eastern outskirts of Calexico, CA. The 704-bed, direct supervision facility is an ICE-dedicated IGSA facility that houses adult male and female detainees of all classification levels in cells and dormitories. Detainees do not incur medical co-pay fees.

The count on the first day of the inspection was 687, of which 57 were female detainees. The average length of stay for a detainee was reported to be 67 days. ICE personnel maintain an office in the facility and interact with detainees daily. Detainees were observed conversing with ICE staff during the inspection.

It was noted that the facility is well maintained and sanitation levels are above average. There is a calm atmosphere. Each housing unit houses 64 detainees. There is a large day room where detainees may watch television and participate in other indoor recreational activities. Each dormitory has an attached outdoor recreation area that is available to the detainees throughout the day. Detainees are also offered two hours outside recreation in the large yard each day. They may participate in walking, jogging, and various sports. They also have access to exercise equipment. Telephones are provided in the units and detainees have access to them during facility waking hours. The facility offers education and training classes to all detainees. The classes currently being offered are: Anger Management, INEA (Mexican Education: Primary and Secondary), Parenting classes, Typing/Computer, Reading Horizon (ESL) and Basic English Reading Education, Meditation, Zumba, Art, Crochet and Guitar.

Detainees were relaxed and spoke freely with inspectors and were observed interacting with facility staff. No less than eighty detainees were interviewed by the inspectors and all stated that they feel safe and that they are treated with respect by staff. LEP detainees stated that they have no problem communicating with staff.
Detainees were questioned about health care, food service, recreation, and access to the law library and other services. None of the detainees voiced any concerns. One detainee stated that his funds had been deposited into his Talton phone account and he was having problems getting the funds transferred to his commissary account. The compliance officer was made aware of the issue.

Facility personnel interviewed were knowledgeable about the requirements of the standards and they stated that they feel safe in the facility and are able to communicate with the detainees.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

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Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden John Rathman, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 26, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 19, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Imperial Regional Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the Imperial Regional Detention Facility during the period of January 17-19, 2018. This is a DIGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Detainee Rights	(b)(6); (b)(7)(C)	
Security		
Medical Care		
Medical Care		
Safety		

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2017 inspection.

Inspection Summary

The Imperial Regional Detention Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 annual inspections:

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2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

Facility Snapshot/Description

The Imperial Regional Detention Facility is owned by the city of Holtville, CA. The city of Holtville has an IGSA with ICE and has contracted with Management and Training Corporation (MTC) to operate the facility. The facility is physically located in the eastern outskirts of Calexico, CA, approximately 130 miles east of the San Diego International Airport. The facility, which opened in 2014, and has an operational capacity of 704 beds, is designated as an ICE-dedicated IGSA that houses adult male ICE detainees of all classification levels and female ICE detainees classified as low and medium custody. The facility does not house juveniles.

The facility is a single level structure containing eleven general population housing units each with a capacity of sixty-four beds. Both cell and dormitory housing are available. All housing units are provided direct supervision. The facility also has a restrictive housing unit which contains sixty-four beds, however, these beds are not counted as part of the operational capacity. On the first day of the inspection the total population was 661 which included 601 male and sixty female ICE detainees. The average daily population for the previous twelve months was 606 male and fifty-seven female detainees with an average length of stay of ninety-four days.

Each general population housing unit has a dayroom area with tables, chairs, two televisions, seven telephones, board games, card games and a sufficient number of showers and wash basins. There is a small outdoor recreation area attached to each general population housing unit which is available to detainees daily between the hours of 7:30 a.m. and 9:00 p.m. Additionally, the facility has a large recreation yard where detainees may engage in various exercise activities such as walking, jogging, basketball, volleyball and intramural games between housing units of appropriate custody designations. Detainees housed in general population have access to this large outdoor recreation area two hours per day, seven days a week. Detainees housed in the restrictive housing unit, for administrative reasons, have access to recreation areas out of their cells for two hours per day, seven days a week, and those housed in disciplinary segregation status have access to the recreation areas one hour per day, seven days a week. Detainees are permitted to participate in the voluntary work program. The facility also offers a variety of educational and training classes to detainees.

Overall, the team found the atmosphere in the facility to be calm with no obvious indicators of high stress. Facility staff was observed interacting with detainees; the interactions appeared to be professional and productive. Sanitation and cleanliness was observed to be above average.

Numerous ICE detainees were interviewed during the course of the inspection. Both male and female detainees, some with limited English proficiency, were interviewed. Some interviews were in a group forum and several were private and confidential. The detainees voiced no concerns regarding life/safety issues. Detainees were generally very satisfied with living conditions and with the interaction and responsiveness of facility and ICE staff.

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One male detainee housed in the restrictive housing unit, administrative segregation, told the Security SME that medical personnel do not visit each detainee in the restrictive housing unit on a daily basis. The SME interviewed several other detainees, detention officers and medical staff. Based on the totality of these interviews and a review of housing unit records, the detainee's assertion that medical personnel do not visit detainees in the restrictive housing unit on a daily basis was not supported.

One female detainee stated she needed a special diet which requires approval by a doctor. The detainee further stated that although she had been seen by a nurse who told her she would be referred to a doctor, she had not yet been seen by the doctor. The Medical SME followed up on this issue and found that the detainee had been interviewed by the nurse approximately one hour prior to voicing her concern to the Lead Compliance Inspector/Detainee Rights SME. Per the medical record, the detainee is scheduled to see a doctor.

The facility houses a substantial number of detainees from India. Several of these detainees stated their desire to have access to Indian television programming. This request was discussed with the OIC and the compliance manager. Both stated that Indian movies are occasionally shown on weekends and that they would further explore the possibility of more television programming from India.

The facility does not charge co-pays for medical, mental health or dental care.

Detainee telephone services are provided via the ICE contract with Talton Communications.

Areas of Concern/Significant Observations

The Medical SME identified a Best Practice regarding the SAAPI program. Every newly arriving detainee receives a one-on-one orientation directly from the SAAPI/PREA coordinator. During this orientation, the detainee is provided counseling to ensure that he or she is knowledgeable about the program. The coordinator uses Language Line when necessary to provide the counseling to detainees who have limited English proficiency. Detainees sign that they have received this information.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS-2011). No standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden (OIC) John Rathman; (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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- Classification Supervisor (b)(6); (b)(7)(C) SAAPI/PREA Coordinator (b)(6); (b)(7)(C) Maintenance Supervisor (b)(6); (b)(7)(C) and various other facility employees.

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 19, 2018

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

January 17, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Imperial Regional Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the Imperial Regional Detention Facility in Calexico, California, during the period of January 15-17, 2019. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2018 inspection.

Inspection Summary

The Imperial Regional Detention Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual inspections:

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2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

Facility Snapshot/Description

The Imperial Regional Detention Facility is designated as an ICE dedicated IGSA (DIGSA) facility owned by the city of Holtville, CA. The city of Holtville has an IGSA with ICE and has contracted with Management and Training Corporation (MTC) to operate the facility. The facility is physically located in the eastern outskirts of Calexico, CA, approximately 130 miles east of the San Diego International Airport. The facility opened in 2014 and has an operational capacity of 704 beds. This DIGSA houses adult male ICE detainees of all classification levels and currently houses female ICE detainees classified as low custody. The facility accepts medium custody female detainees. Juveniles are not housed in this facility.

The facility is a single level structure containing eleven general population housing units. Of the eleven units, two housing units consist of double bed cells. The other nine are open bay dormitories. Both cell and dormitory housing units have a 64 bed capacity. Direct supervision is provided in all housing units. The facility also has a restrictive housing unit which contains 64 beds. However, the beds are not counted as part of the operational capacity. On the first day of the inspection the total population was 661 which included 601 male and sixty female ICE detainees. The average length of stay is 98 days.

Each general population housing unit has a dayroom area with tables, chairs, two televisions, seven telephones, board games, card games and a sufficient number of showers and wash basins. There is a small outdoor recreation area attached to each general population housing unit which is available to detainees daily between the hours of 7:30 a.m. and 9:00 p.m. The facility also has a large recreation yard where detainees may engage in various exercise activities such as walking, jogging, basketball, volleyball and intramural games between housing units of appropriate custody designations. Detainees housed in general population have access to this large outdoor recreation area two hours per day, seven days a week. Detainees housed in the restrictive housing unit, for administrative reasons, have access to recreation areas out of their cells for two hours per day, seven days a week, and those housed in disciplinary segregation status have access to the recreation areas one hour per day, seven days a week. Detainees are permitted to participate in the voluntary work program. The facility also offers a variety of educational and training classes to detainees.

In general, the team found the atmosphere in the facility to be calm with no obvious indicators of high stress. Facility staff was observed interacting with detainees; the interactions appeared to be professional and productive. Sanitation and cleanliness was observed to be above average.

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Numerous ICE detainees, selected at random from all classification levels, were interviewed during the course of the inspection. Both male and female detainees, some with limited English proficiency, were interviewed. Some interviews were in a group forum and several were private and confidential. The detainees voiced no concerns regarding life/safety issues. In general, detainees were satisfied with living conditions and with the interaction and responsiveness of facility and ICE staff. Except for minor concerns about the amount of food provided, the detainees interviewed did not express any other concerns. The food service inspector confirmed that the food portions provided by food service are in compliance with the requirements of the standard.

The facility does not charge co-pays for medical, mental health or dental care.

Detainee telephone services are provided via the ICE contract with TALTON Communications.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations identified during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS-2011). No standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff - Warden (OIC) John Rathman; (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — January 17, 2019

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

January 16, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Imperial Regional Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Imperial Regional Detention Facility in Calexico, California during the period of January 14-16, 2020. This is a CDF facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2019 inspection.

Inspection Summary

The Imperial Regional Detention Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 annual inspections:

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2019 Annual Inspection	
Meets Standard	41
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	1

2020 Annual Inspection	
Meets Standard	41
Does Not Meet Standard	0
Repeat Finding	0
Not Applicable	1

The inspection team identified four (4) deficient components in the following standard:

Food Service—4

Facility Snapshot/Description

The Imperial Regional Detention Facility is owned by the Imperial Valley Gateway Center, LLC. Management and Training Corporation (MTC) has contracted with ICE to operate the facility. The facility is physically located in the eastern outskirts of Calexico, California, approximately 130 miles east of the San Diego International Airport. The facility, constructed in 2014, has a total capacity of 781 beds and an operational capacity of 704 beds. As of December 20, 2019, the facility's designation changed from a dedicated IGSA (DIGSA) to an ICE Contract Detention Facility (CDF). The facility houses adult male ICE detainees of all classification levels and female ICE detainees classified as low and medium custody. On the first day of the inspection the total population was 660 which included 597 male and 63 female ICE detainees. The average daily population for the previous twelve months was 592 male and 64 female detainees with an average length of stay of 101.72 days.

The facility is a single level structure containing eleven general population housing units each with a capacity of 64 beds. Both cell and dormitory beds are available. The facility has a special management unit (SMU) which contains 64 beds. A (b)(7)(E)

(b)(7)(E)

Each general population housing unit has a dayroom area equipped with tables, chairs, two televisions, seven telephones, nine electronic tablets, board games, card games and a sufficient number of showers and wash basins. There is an outdoor recreation area attached to each general population housing unit which is available to detainees daily between the hours of 7:30 a.m. and 9:00 p.m. Additionally, the facility has a large recreation yard where detainees may engage in various exercise activities such as walking, jogging, basketball, volleyball and intramural games between housing units of appropriate custody designations. Detainees housed in general population have access to this large outdoor recreation area two hours per day, seven days a week. Detainees housed in the SMU have access to recreation areas out of their cells one hour per day, seven days a week. Detainees in low and medium-low custody are permitted to participate in the voluntary work program outside of their housing unit. The facility also offers a variety of educational and training classes to detainees.

Each general population housing unit was recently provided nine electronic tablets. Detainees may use an electronic tablet to communicate with various facility and ICE staff, file a grievance, order commissary and access various educational and gaming applications. For a fee, detainees may communicate with family and friends via email, engage in a video visit, or download music and videos.

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Overall, the inspection team found the atmosphere in the facility to be calm with no obvious indicators of high stress. Facility and ICE staff were observed interacting with detainees in the housing units. Sanitation and cleanliness throughout the facility were observed to be above average.

All housing units and common areas of the facility were visited and/or observed during the inspection. No less than fifty detainees were interviewed informally, either individually or in small groups. Twenty-two formal interviews were conducted. Nineteen formal interviews were with detainees with limited English proficiency (LEP); three were with transgender detainees. Language line was used to interview detainees who spoke neither English nor Spanish. A bi-lingual member of the inspection team conducted formal interviews with Spanish speaking detainees. The detainees voiced no concerns regarding life/safety issues. Detainees stated they felt safe and were generally satisfied with the interaction, responsiveness, and professionalism of facility and ICE staff and with access to medical services, mail, the law library, telephones, visitation, and recreation. Detainees expressed general satisfaction with the quantity and quality of food provided.

During detainee interviews, one detainee complained of pain in the back of his head and that he was not getting his prescribed diet. A review of his medical record showed that he was sent for a CT scan of the head which was found to be normal. He also has a low salt diet ordered by the provider.

Three transgender detainees were interviewed and voiced no concerns; the detainees stated they felt safe in this facility.

Some detainees stated that ICE officers do not visit with them in their housing units. The LCI, as part of the Staff-Detainee Communication standard inspection, reviewed this issue. A schedule for ICE visits is posted in each housing unit and each housing unit has a sign-in log which is only used to document ICE visits. The logs substantiated that ICE staff are in the housing units three times weekly on Tuesday, Wednesday and Thursday. ICE officers were observed visiting housing units during the inspection. Detention staff interviewed confirmed that ICE officers routinely visit the housing units and speak to detainees.

Detainee telephone services are provided via the ICE contract with Talton Communications. All other services are provided by MTC.

ICE detainees do not incur medical co-pays.

Areas of Concern/Significant Observation

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No standards were found Does Not Meet Standard and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at

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the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff –Acting Warden (OIC) (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 16, 2020

Printed Name of LCI Date

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The Nakamoto Group, Inc.

February 9, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otero County Prison Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE National Detention Standards (NDS) of the Otero County Prison Facility in Chaparral, NM during the period of February 7 - 9, 2017. This is an IGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Safety	
Medical Care	
QMC	

Type of Inspection

This review is a scheduled annual inspection, which is performed to determine overall compliance with the ICE NDS for Over 72 hour facilities. The facility was not inspected in 2016.

Inspection Summary

The Otero County Prison Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - No
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 NDS compliance annual inspection:

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2016 Annual Inspection	
Meets Standards	N/A
Does Not Meet Standards	N/A
Repeat Finding	N/A
Not Applicable	N/A

2017 Annual Inspection	
Meets Standards	36
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	3

There were no deficient components identified by the inspection team.

Facility Snapshot/Description

The Otero County Prison Facility is a high security correctional facility owned by Otero County, New Mexico and operated under contract by Management & Training Corporation (MTC). The facility is located approximately nine miles northwest of Chaparral, New Mexico and twenty five miles north of El Paso, Texas. Prior to February 3, 2017, when thirty-two female ICE detainees were processed into the facility, there had been no ICE detainees housed in this facility for the past 5 years. Consequently, there is no average length of stay for ICE detainees.

The Otero County Prison Facility was constructed and activated in September 2003. An upgrade to the facility that added eighty additional beds was completed in October 2005. The Otero County Prison physical plant consists of sixteen general population housing units. Fourteen male units have 72 beds each, one housing unit contains sixty beds and one housing unit has 68 beds. There are four separate female housing units; two of these units contain 22 beds and the other two housing units contain eighteen beds. Additionally, the male special management unit (SMU) contains 125 beds and the female segregation unit has 8 beds. There are 6 medical beds and there are 4 beds in the intake area

The facility houses adult male and female detainees for the U.S. Marshals Service, the state of New Mexico, the Federal Bureau of Prisons, Otero County, and the city of Alamogordo, New Mexico. On February 7, 2017, the total facility count was 1,071 of which 32 were female ICE detainees. There were 961 male and 110 female detainees, including the 32 ICE female detainees. The facility can house all classification levels of ICE detainees.

The facility provides detainees with the opportunity to use their time socializing in the dayrooms, watching television, working or participating in indoor/outdoor recreation. There are three indoor recreation areas, in addition there are two outdoor recreation soccer fields, one of which is exclusively for ICE detainees.

All ICE detainees were interviewed and all stated that they felt safe and there were no issues or concerns expressed. Detainees were knowledgeable about the programs and services available. LEP detainees indicated that they had no issues communicating with staff and no problems obtaining services. All the detainees interviewed knew how to contact their assigned ICE officer.

Employees are professional and knowledgeable of their duties and areas of responsibility. All services are provided by MTC employees. ICE detainees do not incur medical co-payments.

The facility is clean and maintains high sanitation standards.

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Areas of Concern/Significant Observations

There were no areas of concern or significant observations identified during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Acceptable. The facility complies with the ICE National Detention Standards (NDS). No (0) standards were found Deficient and three (3) standards were Not Applicable (N/A). All remaining thirty-six (36) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials - (b)(6); (b)(7)(C)
- Facility Staff - Deputy Warden Daniel Peters, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	February 9, 2017
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

February 1, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otero County Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otero County Processing Center in Chaparral, New Mexico during the period of January 29 – February 1, 2018. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the March 2017 inspection.

Inspection Summary

The Otero County Processing Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

2017 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	3

The inspection team identified two (2) deficient components in two (2) standards:

Correspondence and Other Mail – 1, which is a repeat deficiency
Grievance System – 1

Facility Snapshot/Description

The Otero County Processing Center (OCPC) is contracted with the Immigration Customs Enforcement division. The facility is owned by Otero County, New Mexico and operated by Management and Training Corporation (MTC). The facility is located on State Route 54 near Chaparral, New Mexico approximately fifteen miles north of El Paso, Texas. The population on the first day of the inspection was 781 male detainees. The average length of stay is sixteen days. This DIGSA facility houses male ICE detainees of all custody levels. The facility is equipped with office space for ICE officials. There are four courtrooms available for judicial review of on-site detainees.

The three building complex consists of one-story structures with approximately 225,400 total square feet. The complex is comprised of an administration/support building, housing units building and the warehouse. (b)(7)(E)

(b)(7)(E)

(b)(7)(E) There are twenty fifty-bed dormitory-style housing units. Additionally, there is a seventy-six-bed special management unit and a medical housing area capable of housing sixteen detainees. Six detainees were housed in SMU status during the inspection. Total capacity for the facility is 1,086. Each dormitory is furnished with a dayroom, a bank of telephones, televisions and an adequate number of showers, wash basins and toilets. The facility offers indoor and outdoor recreation daily. Detainees were observed playing volleyball, weight lifting, watching television, using the library and visiting. Electronic games and movies are available. Building access is managed by the central control. All detainee movement is escorted.

The facility maintains an excellent level of sanitation and cleanliness. There is a relaxed atmosphere throughout the facility. One unit housing eighteen detainees was in quarantine status due to chicken pox exposure. The detainees showed no restraint in speaking with facility staff, ICE officers or inspectors. Detainees stated that they felt safe and had no concerns communicating with facility staff. No less than ninety detainees were interviewed. The detainees expressed no concerns. Detainees were satisfied with their treatment by staff, living conditions, availability of programs and services and accessibility to ICE personnel and Mexican consulate staff. Facility personnel are experienced and knowledgeable of the daily event schedule, ICE standards and their responsibilities.

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Medical services are provided by Management and Training Corporation Medical. All other services are provided by MTC employees. There is no medical co-pay.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Hassel Terry, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector February 1, 2018

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 31, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otero County Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otero County Processing Center in Chaparral, New Mexico during the period of January 29–January 31, 2019. This is a DIG-SA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2018 inspection.

Inspection Summary

The Otero County Processing Center is currently accredited by:
The American Correctional Association (ACA) – Yes
The National Commission on Correctional Health Care (NCCHC) – Yes
The Joint Commission (TJC) – No
Prison Rape Elimination Act (PREA) – Yes

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Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 compliance annual inspections:

2018 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

2019 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

The inspection team identified two (2) deficient components in the following two (2) standards:

Funds and Personal Property- 1
Correspondence and Other Mail – 1, which is a repeat deficiency

Facility Snapshot/Description

The Otero County Processing Center (OCPC) is owned and operated by the Management and Training Corporation. The facility is located in the desert in the eastern portion of Chaparral, NM, bordered by a United States Military installation and a neighboring correctional facility. This Dedicated IGSA facility houses male ICE detainees of all classification levels. The population during the inspection was 967. The average length of stay is 68 days. There are ICE offices onsite, facilitating a daily onsite presence of several ICE employees. There are four courtrooms available for judicial review of on-site detainees.

The one-story facility encompasses approximately 225,400 total square feet. The complex is comprised of an administration/support building, the housing units building, and the warehouse. (b)(7)(E) (b)(7)(E) There are twenty fifty-bed dormitories, a 76-bed special management unit, and a medical housing area capable of housing sixteen detainees. Sixteen detainees were housed in SMU status during the inspection. Each dormitory is furnished with a dayroom, telephones, televisions, and an adequate number of showers, wash basins, and toilets. The facility offers indoor and outdoor recreation daily. Detainees may participate in volleyball, weight lifting, television viewing, and have use of the library and law library. Additionally, there are electronic tablets in every housing unit that make games, movies, and other entertainment available. The tablets may also be used for video visitation, for a fee.

The facility is clean and orderly. The atmosphere is relaxed throughout the facility. One housing unit was in quarantine status at the onset of the inspection due to chicken pox exposure. The quarantine was lifted during the inspection because the remaining five detainees who had no documented immunity were placed into medical housing. Detainees freely approached the inspectors and facility staff during the inspection.

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No less than 125 detainee interviews were conducted, nineteen of which were formal interviews. Without exception, detainees stated that they felt safe at the facility. LEP detainees reported no issues communicating with facility staff or accessing services. One detainee stated that the water was not hot enough in the showers. The water temperatures were checked and were within the parameters of the Standards. One detainee stated that he wanted the toilets to be fully enclosed. The facility has no plans to install full enclosures around the toilets and the Standards do not require such. Five detainees stated that they wanted more food items offered that are from their home country. They were all from countries that partake in non-traditional foods that are most likely not approved for consumption in the United States. One detainee stated that his mattress was too thin. Mattress width is not addressed by the Standards.

Facility staff were professional in appearance and demeanor, and seemed knowledgeable of the Standards. Most of the staff are bilingual, greatly contributing to the general level of understanding the detainees experience.

Medical services are provided by MTC Medical. All other services are provided by MTC employees. There is no medical co-pay.

Areas of Concern/Significant Observations

There were 93 hunger strikes reported during the inspection period but none requiring outside medical treatment. The facility explained that hunger strikes are occurring in such high numbers among certain nationalities of detainees because they know that when they declare a hunger strike, they are immediately interviewed by ICE staff. It is a method of manipulating the ICE visits to their preference, as opposed to waiting for the next case officer visit to their unit. ICE case officer visits routinely occur no less than one time per week. The detainees of these nationalities housed here apparently believe that they should be catered to at a higher rate of service than other detainees.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

ICE Officials – (b)(6); (b)(7)(C)

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Facility Staff – Warden Dora Orozco, (b)(6); (b)(7)(C)
and various other supervisors and staff

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 31, 2019

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 30, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otero County Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otero County Processing Center in Chaparral, New Mexico during the period of January 28–January 30, 2020. This is a DIG-SA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2019 inspection.

Inspection Summary

The Otero County Processing Center is currently accredited by:
The American Correctional Association (ACA) – Yes
The National Commission on Correctional Health Care (NCCHC) – Yes
The Joint Commission (TJC) – No
Prison Rape Elimination Act (PREA) – Yes

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Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 PBNDS 2011 compliance annual inspections:

2019 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

2020 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

The inspection team identified two (2) deficient components in the following two (2) standards:

Food Service – 1
Interviews and Tours - 1

Facility Snapshot/Description

The Otero County Processing Center (OCPC) is owned and operated by the Management and Training Corporation (MTC). MTC contracts with the Immigration Customs Enforcement (ICE) division of the federal government. The facility is located 27 miles north of the El Paso International Airport in Chaparral, New Mexico. The facility is bordered by a United States Military installation and a neighboring correctional facility. This Dedicated IGSA (DIGSA) facility houses male ICE detainees in all classification levels. There were 890 detainees housed in the facility on the first day of the inspection. The average length of stay was reported by the facility to be 72 days. ICE offices are located on-site. There are also on-site four courtrooms available for judicial review. The inspection team observed ICE officers and ICE supervisors interviewing detainees each day of the inspection.

The one-story facility encompasses approximately 225,400 total square feet. The complex is comprised of an administration/support building, housing unit building and a warehouse. (b)(7)(E) (b)(7)(E) (b)(7)(E) The housing unit consists of twenty fifty-bed dormitories, an 86-bed special management unit, and a sixteen-bed medical housing area. Fourteen detainees were housed in SMU status during the inspection. Each dormitory is furnished with a dayroom, telephones, televisions, and an adequate number of showers, wash basins, and toilets. The facility offers indoor and outdoor recreation daily. Detainees may participate in volleyball, weight lifting, television viewing, and may schedule time for the law library/general library. Additionally, electronic Telmate Tablets are available in each dormitory which provide games, movies, television applications and reading materials. The tablets may be used for video visitation at a cost of $0.21 per minute. Tablets may be used for staff-detainee communication including grievances, sick call and detainee requests (both ICE and facility staff).

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The facility is clean and orderly. The atmosphere is relaxed throughout the facility. Detainees freely approached the inspectors and facility staff during the inspection. Each dormitory was toured on each day of the inspection.

No less than 100 detainee interviews were conducted. Approximately 45 formal interviews were conducted with LEP detainees. Without exception, detainees stated that they felt safe at the facility. During one confidential interview, a detainee voiced a concern regarding his classification level. He stated that he was classified as a level high and did not understand "why he could not be classified as level medium". He advised the SME that he had no criminal history. Follow up confirmed that the detainee had served 21 months in prison. Classification worksheets were reviewed and confirmed the level high classification. Follow up information was shared with the detainee. Four detainees housed in the transgender unit complained that religious services are not offered to them. The chaplain confirmed that he visits the unit twice per week and provides religious materials upon request. LEP detainees reported no issues communicating with facility staff or accessing services. Detainees were observed communicating with the housing unit officers, administrative staff and ICE officers.

Facility staff were professional in appearance and demeanor, and were knowledgeable of the Standards. Most of the staff are bilingual. The orientation to the facility is conducted face-to-face and is comprehensive. The orientation is presented by the department heads.

Medical services are provided by MTC Medical. All other services are provided by MTC employees. There is no medical co-payment.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(7)(E)

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- Facility Staff – Warden Dora Orozco, (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	January 30, 2020
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

March 15, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Rio Grande Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2008 of the Rio Grande Detention Center in Laredo, TX, during the period of March 13-15, 2018. This is an IGSA facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Security	(b)(6); (b)(7)(C)	
Detainee Rights		
Medical Care		
Safety		
Medical Care		

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2008 for Over 72 hour facilities. The facility received a rating of Meets Standards during the March 2017 inspection.

Inspection Summary

The Rio Grande Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2008 compliance annual inspections:

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2017 Inspection	
Meets Standards	39
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	2

2018 Inspection	
Meets Standards	39
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	2

The inspection team identified two (2) component deficiencies in the following two (2) standards:

Medical Care – 1, which is a repeat deficiency
Staff-Detainee Communication - 1

Facility Snapshot/Description

The Rio Grande Detention Center is operated by GEO Corrections. The 276,883 square foot complex occupies 200 acres of land on the outskirts of Laredo, in South Texas, just across the Rio Grande River from Mexico. The 1900-bed facility houses male and female detainees for the United States Marshal Service and male detainees of all classification levels for ICE. During the inspection only Low and Medium custody ICE detainees were being housed. On March 13, 2018 the total count was 1682 with 561 ICE detainees. The average length of stay for an ICE detainee was reported to be fifteen days.

The general population housing units are 84-bed dormitories furnished with sufficient wash basins, showers, toilets and telephones. The dayrooms provide ample space for the detainees to socialize, eat their meals, watch television and participate in board games and other indoor recreation. There are two microwaves in each housing unit and commissary services are available.

The inspection team toured the housing units multiple times during the inspection and detainees were interviewed each time. None of the detainees expressed any concerns about their treatment. All detainees stated that they were treated respectfully by security officers and that they felt safe in the facility. There were no complaints about the quality of the food, access to recreation, the law library, telephones or visiting. There were no complaints about access to medical care or the treatment received. Multiple detainees stated they were taking medication and had no complaints about receiving their medication. There were two minor complaints regarding dental treatment, which upon review by the medical SME, proved unfounded. One detainee had failed to respond to a scheduled appointment and the other had failed to submit a request for treatment.

The atmosphere in the housing units was observed to be relaxed with cordial interaction between officers and detainees. The majority of security staff are bilingual. The cleanliness inside the living units, including showers and bathrooms, was viewed as above average. Case managers are assigned to the housing units and respond to detainee requests promptly. Case managers assist detainees with placing legal/confidential calls and calls to family members who are housed in other facilities. They also conduct Townhall Meetings in the housing units to ensure that the detainees receive the information that they need and to address any concerns. The HSA was observed speaking at one of the meetings to address any concerns about medical care and to ensure that newly arrived detainees are aware of the procedure to request care. ICE personnel were observed meeting with detainees also. Facility command staff make rounds throughout the facility daily.

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Medical care is provided by Correct Care Solutions (CCS). Detainees are not charged medical, dental or mental health co-pay fees.

Areas of Concern/Significant Observations

Just prior to the inspection, two ICE detainees were bitten by a bat in their housing unit. The bat was not preserved for testing for rabies. The detainees were sent to the community hospital for evaluation and are undergoing prophylaxis treatment. During the inspection, several bats were trapped in the housing units. The facility maintenance personnel were inspecting the facility and sealing any possible entry points.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2008. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – Warden Dwight Sims, (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) and numerous other facility staff

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector March 15, 2018

Printed Name of LCI Date

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ICE Uniform Corrective Action Plan

ICE HQ USE ONLY: *(DO NOT EDIT*)*

Review Date: 5/16/2019	**DETLOC: CSCNWWA**	**Review Purpose: Annual**
Complete and Return to ICE HQ No Later Than: 8/29/2019		**Review Type: PBNDS_2011_G324_O72_LYON**
Facility Corrective Action Plan Assigned To: SEA		
Facility Name TACOMA ICE PROCESSING CENTER (NORTHWEST DET CTR)		
Address 1623 E. J STREET		
City: TACOMA	**State: WA**	**Zip Code: 98421**
County PIERCE		
Document Key: 758	**Form Key (Version): 9**	
Document Name: CSCNWWA_05_16_2019_Annual_UCAP_KEY_758.doc		

*If Edits are required, contact ICE HQ for an updated form.

FIELD OFFICE USE: ***(Updates Permitted,** Field Entry Required)*

Date of Final Submission: (Use following format for dates: mm/dd/yyyy)

Form Date: 01-27-2014

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Instructions for Corrective Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the deficiencies identified in the review. Please ensure that each corrective action corrects the noted deficiency to the fullest extent possible. In the event a deficiency cannot be corrected within the authorized timeline, an explanation is required in the "Corrective Actions" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the Field Office must contact the appropriate DMD staff member with this request in advance of the specified timelines for submission.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

Funds and Personal Property (Key: H)

This detention standard ensures that detainees' personal property, including funds, valuables, baggage and other personal property, is safeguarded and controlled, and that contraband does not enter a detention facility.

Item No.	Component	Deficiency Identified	Corrective Action	Projected Completion Date	Date Completed
1	For recordkeeping and accounting purposes, use of the G-589 Property Receipt form is mandatory to inventory any funds removed from a detainee's possession, and a separate form G-589 is required for each kind of currency and negotiable instrument. (Key: H10)	This component was rated as Does Not Meet Standard during the previous inspection because the facility identifies all detainee property on one GEOTrack (jail management system) inventory form. The G-589 is not used for each kind of currency and negotiable instrument removed from the detainee. This is a repeat finding.			

Staff-Detainee Communication (Key: P)

This detention standard enhances security, safety, and orderly facility operations by encouraging and requiring informal direct and written contact among staff and detainees, as well as informal supervisory observation of living and working conditions.

This standard also requires the posting of hotline informational posters from the Department of Homeland Security (DHS) Office of the Inspector General (OIG).

Item No.	Component	Deficiency Identified	Corrective Action	Projected Completion Date	Date Completed
2	In facilities with ICE/ERO on-site presence: The ICE/ERO staff member receiving the request shall normally respond in person or in writing as soon as possible and practicable, but no longer than within 3 business days of receipt. (Key: P04)	This facility has on-site ICE/ERO presence. A review of the detainee written request log revealed that requests are not consistently responded to within three business days of receipt.			

This UCAP has been reviewed and concurred with by an ERO field office official equivalent to an AFOD or above.	
Reviewer Name (Printed):	***Reviewed Date:**

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This UCAP has been reviewed and concurred with by an ERO field office official equivalent to an AFOD or above.	
Reviewer Title (Printed):	
Reviewer Signature (for printed form submission):	

** Field Entry Required*

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The Nakamoto Group, Inc.

February 2, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Eloy Federal Contract Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Eloy Federal Contract Facility, Eloy, AZ during the period of January 31 - February 2, 2017. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2016 inspection.

Inspection Summary

The Eloy Federal Contract Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

2017 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

The inspection team identified one (1) deficient component in the following standard:

Correspondence and Other Mail - 1, which is a repeat deficiency

Facility Snapshot/Description

The Eloy Federal Contract Facility, a DIGSA owned and operated by CoreCivic, formerly known as Corrections Corporation of America (CCA), is located in Eloy, AZ, approximately eighteen miles east of Casa Grande, AZ. The facility houses low, medium, medium-high and high custody adult male and female detainees. The facility has 1596 beds. The population count on the first day of the inspection was 1448 which included 931 male and 517 female detainees. The average length of stay for a detainee is 77 days.

The Eloy Federal Contract Facility was built and opened in 1994. It is a single level building consisting of six housing units, each containing six housing pods with capacities ranging from 43 to 50 beds. Direct supervision is provided during the first and second shifts. Third shift officers provide indirect supervision. Detainees are afforded both indoor and outdoor recreation. Each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks, and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise videos game systems and movies are available. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise areas. The facility provides a generous schedule of activities including karaoke, basketball tournaments, piñata contests, soccer tournaments, holiday tournaments, crochet programs, photograph projects, and Zumba.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. During the inspection the facility was very clean and noise levels were minimal. Supervisors and officers exhibited a professional demeanor in both attire and attitude. Interactions between officers and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC. Food service operations are provided via a contract with Trinity Services Group.

No less than 150 detainees were interviewed during the inspection. Interviews included LEP, detainees in administration and disciplinary segregation, males and females, detainees in each housing unit, confidential interviews. Detainee interviews yielded overall general satisfaction with living conditions, access to the law library, telephones, food services and medical care. Detainees did not express any concerns regarding life and/or safety issues. Conditions of confinement were observed to be above a satisfactory level. Cleanliness standards are consistently high throughout the facility. During the inspection, 120 medical records were reviewed.

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Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Michael Donahue, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector February 2, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

February 8, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Eloy Federal Contract Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Eloy Federal Contract Facility, Eloy, Arizona during the period of February 6 - 8, 2018. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Security	(b)(6); (b)(7)(C)	
Detainee Rights		
Medical Care		
Safety		
Medical Care		

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2017 inspection.

Inspection Summary

The Eloy Federal Contract Facility is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2017 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified one (1) deficient component in one (1) standard:

Staff-Detainee Communication - 1

Facility Snapshot/Description

Eloy Federal Contract Facility (EFCF) is owned and operated by CoreCivic. The City of Eloy has an Intergovernmental Service Agreement (IGSA) with ICE. Eloy Federal Contract Facility is located in Eloy, Arizona, approximately eighteen miles east of Casa Grande, Arizona. The facility houses low, medium, medium-high and high custody adult male and female detainees. The detainee count on the first day of the inspection was 1473, which included 1000 male and 473 female detainees. The average length of stay for a detainee is seventy-six days.

The Eloy Federal Contract Facility was opened in 1994. The physical plant, a one level building, consists of six housing units, each containing six housing pods with capacities ranging from forty-three to fifty beds. Direct supervision is provided during the first and second shifts. Third shift officers provide indirect supervision. Detainees are afforded both indoor and outdoor recreation. Each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks, and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise videos, and movies are available. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise areas. The facility provides a robust schedule of activities including karaoke, basketball tournaments, piñata contests, soccer tournaments, holiday tournaments, crochet programs, photograph projects and Zumba classes.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The facility sanitation levels are above average. Noise levels were observed to be minimal. Supervisors and officers exhibited a professional demeanor in both attire and attitude. Interactions between officers and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC and their contractors. Food service operations are provided by Trinity Services Group, Inc.

No less than 150 detainees were interviewed during the inspection. Interviews included detainees with LEP, detainees in administrative and disciplinary segregation, males and females, detainees in work assignments, detainees in each housing unit, as well as, confidential interviews. Detainee interviews yielded overall general satisfaction with living conditions, and access to law libraries, telephones, food services and medical care. Detainees expressed no concerns regarding life and/or safety issues. Conditions of confinement were

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observed to be above a satisfactory level. Cleanliness standards are consistently high throughout the facility.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Michael Donahue, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

Lynn Cahill-Masching

Lynn Cahill-Masching, Lead Compliance Inspector	February 8, 2018
Printed Name of LCI	Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

February 7, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Eloy Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Eloy Detention Center, Eloy, Arizona during the period of February 5 - 7, 2019. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2018 inspection.

Inspection Summary

The Eloy Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 compliance annual inspections:

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2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

2019 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

The inspection team identified one (1) deficient component in one (1) standard:

Tool Control - 1

Facility Snapshot/Description

Eloy Detention Center (EDC) is owned and operated by CoreCivic. The City of Eloy has an Intergovernmental Service Agreement (IGSA) with Immigration and Customs Enforcement (ICE). Eloy Detention Center, with a capacity of 1596 is located in Eloy, Arizona, approximately eighteen miles east of Casa Grande, Arizona. The facility houses low, medium, medium-high and high custody adult male and female detainees. The detainee count on the first day of the inspection was 1434 which included 797 male and 637 female detainees. The average length of stay for a detainee is 62 days.

Eloy Detention Center was opened in 1994. This is a campus-style facility with individual housing units. The facility is secured by dual security fences. The physical plant consists of eight housing units, six of which consist of five fifty-person pods. Direct supervision is provided during the first and second shifts. Third shift officers provide indirect supervision. Detainees are afforded outdoor recreation, including turf fields, volleyball net, basketball court, track and handball. Each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks, and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise videos, and movies are available. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise areas. The facility provides a robust schedule of activities including karaoke, basketball tournaments, piñata contests, soccer tournaments, holiday tournaments, crochet programs, cleanest pod contest and Zumba classes.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The facility sanitation levels are above average. Noise levels were observed to be minimal. Supervisors and officers exhibited a professional demeanor in both attire and attitude. Interactions between officers and detainees were observed to be respectful and professional.

The facility does not charge a co-payment for medical, mental health or dental care. Health services are provided by IHSC and their contractors. Food service operations are provided by Trinity Services Group, Inc.

No less than 150 detainees were interviewed during the inspection. Interviews included detainees with LEP using the language line, detainees in administrative and disciplinary segregation (males and females), detainees on work assignments, detainees in each housing unit, as well as, confidential interviews. Detainee interviews yielded overall general satisfaction with living conditions, access to law libraries, telephones, food services and medical care. Detainees expressed no concerns regarding life and/or safety issues. During interviews in one of the female pods, several detainees expressed concerns regarding the professionalism of

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two female correctional officers. The detainees stated during confidential interviews "that the officers are rude, disrespectful and intimidating". The warden advised that both officers have been disciplined and are enrolled in the Performance Improvement Program (PIP). Detainees also stated that "some of their issued property needs to be replaced". One detainee showed the inspector her socks which had holes in the bottom of the sock. The unit manager was assigned to follow up and provide new clothing. One LEP detainee stated through the assistance of the language line that she wanted to move to another pod. The other pod housed another detainee who could speak mandarin and English. The unit manager stated that she would follow up immediately to research the detainee request. Conditions of confinement were observed to be above a satisfactory level. Cleanliness standards are consistently high throughout the facility.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Michael Donahue, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector February 7, 2019

Printed Name of LCI Date

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The Nakamoto Group, Inc.

February 6, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Eloy Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Eloy Detention Center, Eloy, Arizona during the period of February 4-6, 2020. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2019 inspection.

Inspection Summary

The Eloy Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 PBNDS annual compliance inspections:

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2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

2020 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified one (1) deficient component in one (1) standard:

Detention Files - 1

Facility Snapshot/Description

Eloy Detention Center (EDC) is owned and operated by CoreCivic. The City of Eloy has an Intergovernmental Service Agreement (IGSA) with Immigration and Customs Enforcement (ICE). Eloy Detention Center, with a capacity of 1,585, is located in Eloy, Arizona, approximately eighteen miles east of Casa Grande, Arizona. The facility houses low, medium-low, medium-high and high custody adult male and female detainees. The detainee count on the first day of the inspection was 1,215, which included 508 male and 707 female detainees. The average length of stay for a detainee is 74 days.

Eloy Detention Center opened in 1994 and was renovated in 2007. The EDC physical plant is campus style with individual housing units. The buildings are primarily constructed of concrete and comprise almost 400,000 square feet of space. There are six general population (one unit is closed at this time) and two special confinement housing units, as well as, seventeen support buildings. (b)(7)(E) (b)(7)(E) The facility includes four courtrooms which are used for deportation hearings. Direct supervision is provided during the first and second shifts. Third shift officers provide indirect supervision. Detainees are afforded outdoor recreation, including turf fields, volleyball nets, basketball court, track and handball. Each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise videos and movies are available. The facility provides a robust schedule of activities including karaoke, basketball tournaments, piñata contests, soccer tournaments, holiday tournaments, crochet programs, cleanest pod contest and aerobic dance classes.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The facility sanitation levels are above average. Noise levels were observed to be minimal. Supervisors and officers exhibited a professional demeanor in both attire and attitude. Interactions between facility officers and detainees were observed to be respectful and professional. Housing unit case managers were observed in each unit. Interactions between ICE officers and detainees were also observed to be respectful and professional.

The facility does not charge a co-payment for medical, mental health or dental care. Health services are provided by IHSC and their contractors. Food service operations are provided by Trinity Services Group, Inc.

No less than 120 detainees were interviewed during the inspection. Interviews included detainees with LEP using the language line and the bilingual SME, detainees in administrative and disciplinary segregation (males and females), detainees on work assignments, detainees

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in each housing unit, as well as, confidential interviews. Detainee interviews yielded overall general satisfaction with living conditions, access to law libraries, telephones, food services and medical care. One detainee complained that she was "stuck with the same needle twice". The medical SME followed up with the medical file and interviewed the medical staff. Follow-up confirmed that proper protocols were followed. Conditions of confinement were observed to be above a satisfactory level.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Fred Figueroa, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector February 6, 2020

Printed Name of LCI Date

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DHS-ICE-20-0618-A-001625

The Nakamoto Group, Inc.

December 14, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc

SUBJECT: **Annual Detention Inspection of the El Paso Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the El Paso Service Processing Center, El Paso, TX during the period of December 12-14, 2017. This is an SPC.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Detainee Rights	(b)(6); (b)(7)(C)	
Security		
Medical Care		
Medical Care		
Safety		

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the December 2016 inspection.

Inspection Summary

The El Paso Service Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) – No (has had PREA audit, waiting for certification)

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	42
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	0

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

Facility Snapshot/Description

The El Paso Service Processing Center is located in El Paso, TX proper, neighboring the El Paso International Airport. It is owned and operated by U.S. Immigration and Custom Enforcement. The facility shares land with the U.S. Border Patrol. The direct supervision facility has a bed capacity of 840 and houses male and female ICE detainees of all classification levels. During the inspection, the population count was 751, which included 560 male and 191 female ICE detainees. The average length of stay for an ICE detainee is 89 days.

There are eight buildings that contain general population living units, all of which are dormitory-style. The administrative and disciplinary special housing units consist of two-person cells. The medical department has a six-bed infirmary ward and three medical isolation cells. Facility staffing is more than adequate, ensuring the provision of detainee services and the security of the compound. Staff are professional in appearance and demeanor. They understand the concepts of civil detention and are familiar with the standards. A large majority of the staff is bilingual.

In general population housing, dayrooms are large and open, and offer numerous activities. Outdoor recreation areas are adjacent to every living unit, and detainees enjoy optimal outside recreation opportunities; that is, no less than two hours per day, seven days per week. Every detainee has a securable personal storage locker in the housing unit. The atmosphere in the housing units was relaxed and detainees freely approached facility staff and the inspection team to converse.

No less than 100 detainees were interviewed during the course of the inspection. Confidential interviews indicated that detainees feel safe at the facility. LEP detainees stated, without exception, that they have no problem accessing services. There were two detainee complaints regarding medical services. One involved the lack of medication and one was about back pain. The Medical SME followed up on both complaints and discovered that the detainee complaining about the lack of medication was in fact receiving the medication prescribed by the physician. The detainee that complained about back pain had 58 contacts with medical services during the course of his stay. His record indicated that he requested marijuana and oxycodone for his treatment. The physician prescribed other medications, which the detainee has refused on eleven occasions. Two detainees complained that their grievances were not responded to. The Safety SME checked, and both detainees had grievances on file that were responded to within the time frame mandated by the standard. Further, the Safety SME did not discover any grievances during his inspection that were not responded to in a timely manner. Two detainees complained that they did not want to wear the electronic anklets that all detainees must wear while detained at the facility. There is no remedy for these complaints, as electronic anklets are not prohibited by the standards. Twenty male and eighteen female detainees were interviewed in the processing area as they were preparing to leave the facility for deportation. Of the 38, only one detainee stated that they had any problems while at the facility, and he declined to provide details.

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The facility issues electronic anklets to every detainee to monitor their location in the facility, as a tool to enhance safety and security. Detainees are required to keep the anklet on at all times. The anklets have the capacity to locate detainees at any time, and also record all detainee movement during their entire stay at the facility. Detainees are permitted to keep no more than $100 cash on their persons. The detainees have access to vending machines, and no commissary is provided. There is no medical co-payment.

IHSC manages and partially staffs the medical services department, with the contractor InGenesis providing supplemental medical staff. GPS/Asset Security provides detention, transportation, and food services for the facility. Argos Security provides Quality Assurance services; Mavagi performs the janitorial services; and K-CORP provides maintenance service for the facility.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. One (1) standard was rated as Not Applicable. The remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C) and various other contract employees

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector	December 14, 2017
Printed Name of LCI	Date

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The Nakamoto Group, Inc.

December 13, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc

SUBJECT: **Annual Detention Inspection of the El Paso Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the El Paso Service Processing Center, El Paso, TX during the period of December 11-13, 2018. This is an SPC.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the December 2017 inspection.

Inspection Summary

The El Paso Service Processing Center is currently accredited by:
The American Correctional Association (ACA) - Yes
The National Commission on Correctional Health Care (NCCHC) - Yes
The Joint Commission (TJC) - No
Prison Rape Elimination Act (PREA) – Yes

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Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified five (5) deficient components in the following two (2) Standards:

Environmental Health and Safety- 1
Food Service- 4, one of which is a Priority Component

Facility Snapshot/Description

The El Paso Service Processing Center is located in El Paso, TX, in a largely industrial area close to the El Paso International Airport. It is owned and operated by U.S. Immigration and Custom Enforcement. The facility shares land with the U.S. Border Patrol. The direct supervision facility has a bed capacity of 840 and houses male and female ICE detainees of all classification levels. During the inspection the population count was 681, which included 519 male and 162 female ICE detainees. The average length of stay for an ICE detainee is 74 days.

There are eight buildings that contain general population living units, all of which are dormitory-style. The administrative and disciplinary special housing units consist of two-person cells. The medical department has a six-bed infirmary ward and three medical isolation cells. Staffing is adequate. Staff were professional in appearance and demeanor while interacting with the inspection team. Many staff displayed an understanding of the concepts of civil detention and were familiar with the standards. A large majority of the staff is bilingual.

Dayrooms are large and open, and offer numerous activities. Outdoor recreation areas are adjacent to every living unit, and detainees are offered outdoor recreation for no less than two hours per day, seven days per week. Every detainee has a securable personal storage locker in the housing unit. The facility operates at optimal levels in terms of telephone access and law library access. The atmosphere in the housing units was relaxed and detainees freely approached the inspection team members to ask questions or discuss their issues.

No less than 92 detainees were interviewed during the course of the inspection, twenty of which were formal interviews. Confidential interviews indicated that detainees feel safe at the facility, with the exception of three detainees: Two of them had lodged formal complaints prior to the inspection, and the third detainee's complaint was elevated to the Assistant OIC by the inspection team during the inspection. Interviews with LEP detainees indicated that they have no problem accessing services. Several detainees complained that the facility does not have good mir-

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rors. They were advised that the Standards do not require mirrors. One detainee complained that there is no commissary at the facility. He was advised that the Standards do not require commissaries. One detainee inquired about the availability of notary services, and he was directed to the appropriate source. One detainee stated that he filed a number of grievances and they were not responded to. The Safety SME checked the grievance log and determined that the detainee had filed one grievance, which was responded to. It was denied based on two staff witness statements. Two female detainees stated that they filed grievances about unfair treatment from corrections officers. The Safety SME determined that there was a grievance from these detainees, with their names, and several other detainee names, listed on the grievance as complainants. The grievance officers indicated that the allegations are under investigation. One detainee complained that she was misdiagnosed for stomach issues. The Medical SME checked the medical record and determined that the detainee had an ultrasound, which did not show anything. The medical staff then ordered an abdominal CT scan, and a gall stone was found. Surgery was performed successfully. One male detainee complained that two officers were treating him badly. The detainee claimed that he was too afraid to complain through any of the systems in place. The Assistant OIC was informed and he indicated that he would initiate a proper investigation. One detainee stated that he wanted larger food portions. The Safety SME determined that the food portions are within the requirements of the Standard and are in compliance with the nutritional analysis. Two detainees complained of minor medical problems. The Medical SME checked the medical records and determined that both detainees had received appropriate medical attention. Three detainees complained that they had only seen their ICE Officer one time during their detention. However, they then stated that an ICE Officer comes into their housing unit to return request forms and interview detainees frequently. The housing unit logs confirmed that the ICE Officer visits the housing units every Tuesday and Thursday to interview detainees and provide responses to request forms.

The facility issues electronic anklets to every detainee to monitor their location in the facility, as a tool to enhance safety and security. Detainees are required to keep the anklet on at all times. The anklets have the capacity to locate detainees at any time, and also record all detainee movement during their entire stay at the facility. Detainees are permitted to keep no more than $100 cash on their persons. The detainees have access to vending machines, and no commissary is provided. There is no medical co-payment.

IHSC manages and partially staffs the medical services department, with the contractor InGenesis providing supplemental medical staff. GPS/Asset Security provides detention, transportation, quality assurance, and food services for the facility; Mavagi performs the janitorial services; Jesuit Refugees Services provides contract chaplaincy services; and K-CORP provides maintenance service for the facility.

Areas of Concern/Significant Observations

The inspection team observed small amounts of mold beginning to form in some of the showers.

(b)(5)

Priority Component #10 in the Food Service Standard was rated as Does Not Meets.

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PRIORITY: Before and during the display, service, and transportation of food, sanitary guidelines are observed, with hot foods maintained at a temperature of at least 140 F degrees and foods that require refrigeration maintained at 41 F degrees or below.

Finding: The temperature of the jello being served during the lunch meal of the first day of the inspection was recorded as being between 42 F degrees and 52 F degrees.

Recommendation: (b)(5)

(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. One (1) standard was rated as Not Applicable. The remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

ICE Officials – (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Facility Staff – (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) and various other contract employees

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector December 13, 2018

Printed Name of LCI Date

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001632
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The Nakamoto Group, Inc.

December 12, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the El Paso Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the El Paso Service Processing Center in El Paso, Texas, during the period of December 10-12, 2019. This is an SPC facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards as a result of the December 2018 annual inspection.

Inspection Summary

The El Paso Service Processing Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual inspections:

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2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified two (2) deficient components in the following two (2) standards:

Use of Force and Restraints - 1
Significant Self-Harm and Suicide Prevention and Intervention - 1

Facility Snapshot/Description

The El Paso Service Processing Center is an immigration detention facility located in El Paso, Texas, near the El Paso International Airport. It is owned and operated by U.S. Immigration and Custom Enforcement (ICE). The facility shares land with the U.S. Border Patrol Sector Headquarters and an El Paso Border Patrol Station. The facility houses all classification levels of ICE detainees who are either awaiting deportation or have pending cases before the El Paso Immigration Court. The facility, originally constructed in 1966 and renovated with new construction in 1996, has a capacity of 840 beds. On the first day of the inspection the total population count was 785 which included 512 male and 273 female ICE detainees. The average daily population for the inspection period was 815 with an average length of stay of 48 days.

Ten buildings at the complex contain beds for housing detainees. All general population housing is dormitory/open bay with capacities ranging from twenty beds to 74 beds. Two buildings house the special management units (SMU); there are seven double cells for administrative segregation housing in one of the buildings and six single cells in the building designated for disciplinary segregation. Male and female detainees may be housed in either of the SMU buildings. Six of the ten buildings are military barracks style design and two buildings are a more traditional institutional design with four housing pods surrounding a control center. Linear supervision is employed on the campus style layout, i.e., officers are stationed outside the buildings in order to observe detainee movement throughout the compound. Direct supervision is provided for detainees by a custodial officer stationed inside each of the general population housing pods. Direct and irregular supervision is employed inside the SMU. Additionally, the facility issues electronic ankle bracelets to every detainee to monitor their location within the facility as a tool to enhance safety and security. Detainees are always required to wear the ankle bracelet.

Outdoor recreation is available seven days per week, two hours per day, in several outdoor recreation yards. Additionally, the general population housing units provide adequate open space for detainees to socialize and move freely between their assigned bunks and the dayroom area. Each housing unit is equipped with tables and seats, televisions, telephones, vending machines, and board games. Some of the housing units also have foosball and ping-pong tables. Detainees are permitted to keep up to $100 cash on their person to use in the vending machines; the facility does not have a commissary. Detainees may also check out a tablet on which at no charge they can communicate with various facility staff and ICE, file a grievance, and access a version of LexisNexis. For a fee, detainees can download music and videos, make telephone calls, and visit via video with family and friends. Depending on custody level, detainees may participate in the voluntary work program. The atmosphere during the inspection was calm and detainees were observed interacting with staff and other detainees. Most staff at the facility speak English and Spanish. Overall cleanliness and sanitation were observed to be average.

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Numerous detainees were interviewed. Some interviews were in housing units, programmatic areas, or work areas with individuals or small groups of detainees. Several interviews were private and confidential and included detainees with limited English proficiency (LEP). Language line was used to facilitate interviews with detainees who spoke neither English nor Spanish. A bilingual member of the inspection team conducted private interviews with several Spanish speaking detainees from various countries. Interviews included detainees who had recently arrived at the facility and some who had been housed at the facility for longer periods of time. Both male and female detainees were interviewed. The detainees voiced no life safety concerns. All the detainees interviewed stated they felt safe and were generally satisfied with the interaction, responsiveness, and professionalism of facility and ICE staff and with access to medical services, mail, the law library, telephones, visitation, and recreation. Detainees expressed general satisfaction with the quantity and quality of food provided. Two detainees from Romania stated they did not care for the food; not because it was of poor quality but because it was different from what they eat at home. Two detainees from China asked if the rules could be made available to them in their language. This request was shared with the SDDO.

Detainee telephone services are provided via the national ICE contract with Talton Communications. Security services, transportation, food service operations, mail processing, recreation supervision, and the librarian are contracted with GPS-Asset. IHSC has on-site oversight of medical services which are supplemented through a contract with STG International.

ICE detainees do not incur medical co-pays.

Areas of Concern/Significant Observation

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS 2011). One standard was rated Not Applicable. The remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials - (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff - (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) and various other GPS-Asset contract employees

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	December 12, 2019
Printed Name of LCI		Date

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001636
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The Nakamoto Group, Inc.

January 12, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc

SUBJECT: **Annual Detention Inspection of the Houston Contract Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Houston Contract Detention Facility, Houston, TX during the period of January 10-12, 2017. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
QMC	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2016 inspection.

Inspection Summary

The Houston Contract Detention Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following standard:

Hold Rooms in Detention Facilities – 1, which is a priority component

Facility Snapshot/Description

The Houston Contract Detention Facility, a CDF, is owned and operated by CoreCivic. The original building was constructed in 1983 and was expanded in 2004. The facility is located in an industrial district approximately 3.3 miles southeast of the Houston George Bush Intercontinental Airport. The facility houses low, medium and high custody adult male and female detainees for ICE. The total facility capacity is 1000. The population count on the first day of the inspection was 1094 which included 933 male and 161 female ICE detainees. The average length of stay for ICE detainees for the previous twelve months was 68 days with an average daily population of 925 detainees; 722.5 males and 202.5 females.

The Houston Contract Detention Facility is a one-level, single building structure consisting of 27 dormitories with capacities ranging from twenty to sixty general population detainees. Additionally, there is a 34 bed segregation unit for males and a four bed segregation unit for females. All housing units are provided direct supervision. Detainees are afforded the opportunity for both indoor and outdoor recreation and detainees were observed participating in both areas. Each dormitory has a large dayroom area equipped with tables, chairs, televisions, board games and microwaves. The entire facility is climate controlled. Telephones are available in the general population housing units at an optimal ratio of one telephone for every ten detainees. Each detainee wears a uniform and wristband which is color coded according to custody level. Each wristband also contains the photograph of the detainee to which it is assigned.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. During the inspection the facility was very clean and noise levels were minimal. All staff encountered by the inspection team exhibited a professional demeanor. Interactions between staff and ICE detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC. Food service operations are contracted with Trinity Services Group. Transportation services are contracted with TransCor America, LLC.

The QMC and Medical SMEs reviewed 192 medical files during the inspection. Combined, all of the SMEs interviewed no less than fifty ICE detainees, both men and women. Some interviews were confidential and included detainees who had limited English proficiency. Detainees' statements indicated general satisfaction with living conditions, access to the law library, telephones and medical care. Detainees did not express any concerns regarding life and safety issues.

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Several detainees stated they had not received a handbook upon arrival. The Detainee Rights SME checked the detention files of these detainees and found that in every case the detainee had signed for receipt of the handbooks (both the National Detainee Handbook and the local supplement are issued during intake). One detainee complained that he was not receiving treatment for a previous injury to his left arm. The medical SME reviewed this detainee's medical file and found that he is scheduled for specialty therapy clinic later this month.

Areas of Concern/Significant Observations

Priority Component Rated Does Not Meet Standard

Hold Rooms in Detention Facilities
Component #4 - Detainees are not held in hold rooms for more than twelve hours.

Finding: Several detainees were found to be held in hold rooms for more than twelve hours due to the number of detainees at the facility exceeding the bed capacity.

Recommendation: (b)(5)
(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Robert Lacy, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C) and various supervisors and staff.

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 12, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 11, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Houston CDF**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Houston CDF in Houston, TX, during the period of January 9-11, 2018. This is a CDF facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a rating of Meets Standards during the January 2017 inspection.

Inspection Summary

The Houston CDF is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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AMERICAN OVERSIGHT

2017 Inspection	
Meets Standards	41
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	1

2018 Inspection	
Meets Standards	41
Does Not Meet Standards	0
At-Risk	0
Repeat Finding	0
Not Applicable	1

Facility Snapshot/Description

The Houston CDF is a 1000-bed contract detention facility operated by CoreCivic (formerly Corrections Corporation of America). The facility is located in the Northeast section of Houston, Texas near Bush Intercontinental Airport. The facility is a one-story, single building facility encompassing 182,786 square feet. The detainee housing areas consist of twenty-seven (27) dormitories that house from twenty (20) to sixty (60) detainees, a four (4) cell female segregation unit, a thirty-four (34) cell male segregation unit and a fourteen (14) bed medical short stay unit that includes negative air pressure cells. All dormitories have large dayroom areas equipped with televisions, telephones and a microwave. Board games, puzzles, cards and X-box are provided for indoor recreation. The outdoor recreation areas provide a track, basketball, soccer and handball courts and a covered area. The facility houses male and female ICE detainees of all classification levels. The count during the inspection was 921 of which 143 were female. The average length of stay was reported to be 75.8 days for male detainees and 69.9 days for female detainees.

It was noted that the facility was clean, well maintained and there was a calm atmosphere. Detainees were relaxed and spoke freely with inspectors and were observed interacting with facility staff.

No less than one hundred detainees were interviewed by the inspectors. Detainees stated that ICE personnel visit them often and are responsive to their requests. All detainees stated that they feel safe at the facility and that all the officers treat them with respect. LEP detainees stated that they have no problem communicating with staff as many of them are bi-lingual. No detainees voiced any substantive complaints. Numerous detainees complained that the food was cold. The Safety SME followed-up on the complaint and it was determined that the food temperatures were within standards. All housing units operate under a unit management system complemented by a case manager and counselors. Shift supervisors, case managers and unit managers were observed in the housing units making rounds and interacting with the detainees throughout the inspection. All personnel interviewed were well-versed in the requirements of the standards and the concept of civil detention.

Food Services are contracted to Trinity Services Group. Health care is provided by IHSC. Detainees are not charged medical, dental or mental health co-pay fees.

Areas of Concern/Significant Observations

There were no areas of concern identified during this inspection.

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Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Robert Lacy, Jr., (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 11, 2018

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

January 10, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Houston CDF**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Houston CDF in Houston, TX during the period of January 8-10, 2019. The facility is a CDF.

The annual inspection was performed under the guidance of Dolores Messick, Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2018 inspection.

Inspection Summary

The Houston CDF is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 compliance annual inspections:

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2018 Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2019 Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following standard:

Significant Self-Harm and Suicide Prevention and Intervention – 1, which is a Priority component

Facility Snapshot/Description

The Houston CDF is a 1,000-bed contract detention facility operated by CoreCivic. The facility is located in the Northeast section of Houston, Texas near Bush Intercontinental Airport. The facility is a one-story, single building facility encompassing 182,786 square feet. The detainee housing areas consist of twenty-seven (27) dormitories that house from twenty (20) to sixty (60) detainees, a four (4) cell female segregation unit, a thirty-four (34) cell male segregation unit and a fourteen (14) bed short stay unit that includes negative air pressure cells. The facility houses male and female ICE detainees of all classification levels. The count on the first day of the inspection was 944 of which 146 were female. The average length of stay was reported to be thirty to thirty-five days. During the inspection, five housing units were designated as COHORT units due to an outbreak of mumps beginning in December. Four active cases of mumps were being housed in the alternative housing unit.

All dormitories have large dayroom areas equipped with television, telephones and a microwave. Board games, puzzles, cards and X-Box are provided for indoor recreation in the housing units. Exercise areas for both male and female detainees provide a variety of equipment. The outdoor recreation areas provide a track, basketball, soccer and handball courts and a covered area. Opportunities for intramural competition between housing units are provided.

The detainees were observed socializing in the dayrooms and engaging in activities in the outdoor recreation areas. Supervisors and officers were professional in demeanor and attire. They were observed interacting with detainees in the housing units. It was noted that detainees greeted the Warden and Assistant Warden during the tour of the facility and it was obvious that the detainees were used to seeing them and other command staff in the housing units. All housing units operate under a unit management system complemented by a case manager and counselors. Case manages and unit managers were observed in the housing units making rounds and interacting with the detainees throughout the inspection.

The inspection team visited the housing units multiple times during the inspection, interviewing detainees in groups and in a confidential setting. All detainees stated that they felt safe at the facility and they were treated with respect by facility and ICE personnel. LEP detainees stated that they have no problem communicating with staff as many of them are bi-lingual and the language line is utilized if needed. Confidential interviews were conducted with male and female detainees ranging in age from 22-66 years of age. The detainees have been housed at the facility from three weeks to two years. Only two detainees voiced complaints. Both detainees were female. One stated that the food was bland and not seasoned to her liking. The other complained that she did not receive adequate medical treatment for chest pain and that she was not being treated for her high blood pressure. She stated that was not evaluated/treated by medical staff. The complaint was forwarded to the medical SME who reviewed the detainee's medical record. It was noted that the detainee was on blood pressure medication and reported to sick call on October 24, 2018 complaining of chest pain off and on for about one week. The detainee was evaluated and EMS was called after phone consultation with the clinical director. EMS performed their initial evaluation and were about to transport the detainee when she refused to go. Based on review

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of the medical record, this detainee has received proper monitoring of her blood pressure and treatment for her multiple medical complaints.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. During the inspection, sanitation at the facility was observed to be above average and noise levels were minimal.

ICE detainees are not charged medical co-payments. Medical care is provided by IHSC uniformed and contract personnel. Food Services are contracted to Trinity Services Group.

Areas of Concern/Significant Observations

4.6 Significant Self Harm and Suicide Prevention and Intervention

Priority Component #3: Detainees who are identified as being "at risk" for significant self-harm or suicide shall immediately be referred to a mental health provider, who shall evaluate the detainee within 24 hours of the referral.

Finding: Review of medical records confirmed that detainees who are identified as being "at risk" are immediately referred to a behavioral health provider but are not always evaluated within 24 hours of referral. One of seventeen detainees on suicide watch since the last inspection was not evaluated by a mental health professional within 24 hours.

Recommendation: (b)(5)
(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Robert Lacy, Jr., (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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The Nakamoto Group, Inc.

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector

January 10, 2019

Printed Name of LCI

Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

January 9, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the Houston CDF**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Houston CDF in Houston, Texas during the period of January 7-9, 2020. The facility is a CDF.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2019 inspection.

Inspection Summary

The Houston CDF is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 annual inspection and 2020 annual inspection.

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2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2020 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified zero (0) deficient components.

Facility Snapshot/Description

The Houston CDF is a contract detention facility operated by CoreCivic and located near Bush Intercontinental Airport in Houston, Texas. The single-story facility maintains 1,000 bed capacity and was built in 1984 with physical plant upgrades in 2005. Facility security and unit management staff directly supervise all custody levels of adult male and female detainees for ICE. The count on the first day of the inspection was 658; including 91 female detainees. The average length of stay for ICE detainees was reported to be fifty days.

Detainees are housed throughout 26 dormitories that range from twenty to sixty bed housing areas. Male detainees occupy 22 of the housing units; while the six remaining housing units are reserved for female detainees. There is a four-cell female segregation unit and a 32-cell male segregation unit. The medical unit has sixteen beds, including four negative air pressure cells. Living units are well lit with both natural and artificial light and have adequate open space for detainees. The dayrooms in each of the housing units are furnished with tables and chairs for detainees to participate in leisure time activities, socialize and eat their meals. Detainees were observed playing board games, reading, playing cards, visiting, watching television, and talking on the telephones. Computer tablets were recently installed in the living units to assist detainees in communicating with ICE staff, ordering commissary items and checking their account balances. The facility provides large indoor and outdoor recreation areas separately for male and female detainees. The female outdoor recreation area is equipped with exercise stations, basketball court and a flower garden for detainees to plant and care for flowers. The male outdoor recreation area has a basketball court, weight machine and a designated area to play soccer. Indoor recreation areas for both male and female detainees are equipped with stationary exercise bicycles and basketball courts.

The entire facility is climate controlled. The inspection team found the environment to be relaxed with detainees freely approaching inspectors, ICE officials and facility personnel to participate in formal interviews and general discussions. The facility appeared in good repair and the sanitation level was found to be above average. All officers interviewed were well-versed in facility guidelines and operating procedures as well as the National Detention Standards. Officers and staff were professional when dealing with detainees and the inspection team.

The inspection team conducted several open and confidential interviews with LEP and English-speaking detainees using the language line interpreter service. There were no substantive concerns voiced when asked about their personal safety, ICE services, treatment by staff, access to telephones, access to the law library, or food services. Most detainees expressed appreciation for the variety of exercise equipment, but some stated that they would like more than one hour a day of outside recreation. During one LEP confidential interview, a female detainee of Spanish descent shared that she had pending criminal charges at the time that ICE detained her and was concerned that she would be cited for failing to attend the court proceedings. Unit management personnel were made aware of her concern and the detainee was immediately shown how to use the computer tablet to request a meeting with the ICE officer.

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The facility does not charge co-pays for medical, mental health, or dental care. Medical care is provided by IHSC uniformed and contract personnel. Food services is contracted with Trinity Services Group.

Detainee telephone services are provided by Talton Communications, Inc., via contract with ICE.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Robert Lacy, Jr., (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	January 9, 2020
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

September 14, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the LaSalle ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the LaSalle ICE Processing Center in Jena, LA during the period of September 12-14, 2017. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Safety	
Medical Care	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the September 2016 inspection.

Inspection Summary

The LaSalle ICE Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 PBNDS 2011 annual compliance inspection:

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2016 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following standard:

Hold Rooms In Detention Facilities – 1

Facility Snapshot/Description

The LaSalle ICE Processing Center is owned by the Geo Group, Inc. The Geo Group has an intergovernmental services agreement with ICE and the LaSalle Economic Development District. The facility is located in a rural area on the outskirts of Jena, Louisiana. The facility is a dedicated IGSA facility housing male and female detainees of all security classification levels. On September 13, 2016, the facility count was 1,180, including 1,066 male detainees and 114 female detainees. The average length of stay is 12 days. An onsite administrative building serves the needs of ICE officials and the Executive Office of Immigration Review (EOIR).

(b)(7)(E)

(b)(7)(E) The housing units consist of thirteen dormitory bays as well as four units equipped with two-person cells ranging in size from 24to48 beds. Detainees in the housing areas are directly supervised by assigned housing unit officers and are under constant camera surveillance. Housing units provide generous open space. Detainees spend the majority of their time socializing in the dayrooms, watching television, working or participating in indoor/outdoor recreation activities. There is also a game room provided outside of the housing unit with multiple television stations and X-boxes for detainee use during recreation time. The outdoor recreation areas are adjacent to the housing units.

Every housing unit was inspected by one or more inspection team members. Without exception, detainees stated that they felt safe. A minimum of 200 interviews included: detainees with limited English proficiency; males and females; detainees housed in general population and the restricted housing unit; detainees in the recreation areas and several detainees being processed for release. Detainees were knowledgeable about the services available. LEP detainees indicated that they had no issues communicating with staff and no problems obtaining services. All the detainees knew how to contact ICE personnel. Documentation confirmed that the detainees are receiving responses from the ICE officers in a timely manner. A review of the medical files confirmed that detainees receive required medical services in a timely manner.

Sanitation is maintained at an above average level throughout the facility.

Facility employees are a professional workforce, and skilled in the administration of the PBNDS 2011 standards. Medical services are provided by IHSC clinicians and contracted support services. All other services are provided by GEO Group employees. ICE detainees do not incur medical co-payments.

The Medical SME and QMC SME reviewed 127 medical charts during this inspection.

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Areas of Concern/Significant Observations

Priority Component Rated Does Not Meet Standard

Hold Rooms in Detention Facilities

Component #4 - Detainees are not held in hold rooms for more than twelve hours.

Finding: A review of detention/intake logs from 09/01/2017 to 09/07/2017 revealed four instances in which detainees were being held in hold rooms for more than twelve hours.

Recommendation: (b)(5)

(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. Forty-one (41) standards were found to Meet Standards. One (1) standard is Not Applicable.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – Warden David Cole, (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector September 14, 2017

Printed Name of LCI Date

AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

September 27, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the LaSalle ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the LaSalle Ice Processing Center in Jena, LA, during the period of September 25-27, 2018. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the September 2017 inspection.

Inspection Summary

The LaSalle Ice Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 annual inspections:

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2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Finding	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following standard:

> Hold Rooms in Detention Facilities – 1, which is a Priority component and a repeat deficiency

Facility Snapshot/Description

The LaSalle ICE Processing Center is owned and operated by the Geo Group, Inc. The Geo Group has an intergovernmental services agreement with ICE and the LaSalle Economic Development District. The facility is located in a rural area on the outskirts of Jena, Louisiana. The facility is a dedicated IGSA facility (DIGSA) housing adult male and female ICE detainees of all security classification levels. On September 25, 2018 the facility count was 1,216, including 1,054 male and 192 female detainees. The average length of stay was reported to be sixteen days. An onsite administrative building serves the needs of ICE officials and the Executive Office of Immigration Review (EOIR). ICE staff assigned to the facility includes an AFOD, three SDDOs and seven DOs.

The 1,160-bed facility consists of (b)(7)(E) (b)(7)(E) (b)(7)(E) Detainees are housed in a combination of dormitories and celled units and are directly supervised by assigned housing unit officers. The housing units provide generous open space. Detainees spend the majority of their time socializing in the dayrooms, watching television, or participating in indoor or outdoor recreational activities. The outdoor recreation areas are adjacent to the housing units. General population detainees are permitted four hours of outdoor recreation per day, seven days a week.

An inspection of the housing units, medical unit, and the facility overall reflected a positive environment, with above-average sanitation conditions being observed. There were no issues or concerns expressed by detainees in regard to conditions of confinement or quality of life. Numerous detainee interviews were conducted both in groups and individually. Detainees stated they felt safe and were satisfied with the sanitation conditions in the facility. All stated they were treated respectfully by the officers and were receiving the services that the standards require. There were no substantive complaints regarding the food. One detainee stated that he was not receiving the appropriate diet. Investigation of this issue revealed that the detainee is required to receive a soy free diet and that the food service department is in fact providing the appropriate diet.

Several LEP detainees from general population and the Special Management Unit were interviewed in Spanish using the telephonic translation service. One general population female detainee stated that she was not able to speak with the ICE officer because she did not speak English. The AFOD was notified of her concern. Two male and one female LEP detainees who were housed in the Special Management Unit were interviewed. The female detainee expressed no concerns about her treatment. One male detainee

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stated he was being treated in a disrespectful manner by a single officer on the night shift and was thinking of harming the officer. This information was passed on to the chief of security and the SMU sergeant who both stated they would follow up on the issue. The other male detainee stated he had no complaints about his treatment at the facility but stated he had just been transferred to the facility and had not received his funds from the previous facility. This information was passed on to the chief of security who stated he would follow-up on the issue.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC. Commissary services are provided by Keefe. All other services are provided by GEO Group employees.

Areas of Concern/Significant Observations

The inspection team identified one (1) deficient priority component:

Hold Rooms in Detention Facilities

Component #4: Detainees are not held in hold rooms for more than twelve hours.

Finding: A review of detention/intake logs from 9/22/2017 to 10/31/2017 revealed three instances in which significant numbers (73) of detainees were held in the hold rooms for more than twelve hours.

Recommendation: (b)(5)
(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011 for Over 72 hour facilities. No (0) standards were found Does Not Meet Standards. Forty-one (41) standards were found to Meet Standards and one (1) standard was Not Applicable (N/A).

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff –Warden David C. Cole, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector September 27, 2018

Printed Name of LCI Date

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001655

The Nakamoto Group, Inc.

September 26, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the LaSalle ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the LaSalle Ice Processing Center in Jena, Louisiana, during the period of September 24-26, 2019. This is a DIGSA facility.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the September 2018 inspection.

Inspection Summary

The LaSalle Ice Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual inspections:

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2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified one (1) deficient component in the following standard:

Law Libraries and Legal Materials - 1

Facility Snapshot/Description

The LaSalle ICE Processing Center is owned and operated by The Geo Group, Inc. (GEO), who has an intergovernmental services agreement with ICE and the LaSalle Economic Development District. The facility is located in a rural area on the outskirts of Jena, Louisiana. The facility is a dedicated IGSA (DIGSA) facility housing adult male and female detainees of all security classification levels. On September 24, 2019 the facility count was 1,254, including 965 male and 289 female detainees. The average length of stay was reported to be 56 days. An onsite administrative building is used by ICE and Executive Office of Immigration Review (EOIR) officers. Three Supervisory Detention and Deportation Officers (SDDO) and seven Deportation Officers (DO) are detailed to the facility.

The 1,328-bed facility consists of (b)(7)(E) (b)(7)(E) (b)(7)(E) Detainees are housed in a combination of dormitories and celled units and are directly supervised by assigned housing unit officers. The housing units provide generous open space. Detainees spend the majority of their time socializing in the dayrooms, watching television, using the electronic tablets (video visitation, video chatting, messaging, games, library of books, law library, movies and music) or participating in indoor or outdoor recreational activities. The outdoor recreation areas are adjacent to the housing units. General population detainees are permitted four hours of outdoor recreation per day, seven days a week.

An inspection of the housing units, medical unit, and the facility overall reflected a positive environment, with above-average sanitation conditions being observed. There were no issues or concerns expressed by detainees in regard to conditions of confinement or quality of life. No less than 100 detainee interviews were conducted. Detainees stated they felt safe and were satisfied with the sanitation conditions in the facility. All stated they were treated respectfully by the officers and were receiving services required by the standards. Two detainees requested housing unit changes “due to concerns with gang activities”. The concern was shared with the warden and classification specialist. The classification specialist will follow-up with the concern. Several LEP detainees from general population and the Special Management Unit were interviewed using the telephonic translation service. One detainee complained about the price of commissary items. The concern was shared with the warden.

The facility does not charge a co-pay for medical, mental health or dental care. Health services are provided by IHSC. Commissary services are provided by Keefe. All other services are provided by GEO employees.

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Areas of Concern/Significant Observations

There were no areas of concern observed during the inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011 for Over 72 hour facilities. No (0) standards were found Does Not Meet Standards, forty-one (41) standards were found to Meet Standards and one (1) standard was Not Applicable (N/A).

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff –Warden David C. Cole, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	September 26, 2019
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

February 2, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Port Isabel Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Port Isabel Service Processing Center, Los Fresnos, TX during the period of January 31- February 2, 2017. This is an SPC facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
QMC Toolkit SME	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2016 inspection.

Inspection Summary

The Port Isabel Service Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Inspection	
Meets Standards	42
Deficient	0
At-Risk	0
Repeat Finding	0
Not Applicable	0

2017 Inspection	
Meets Standards	42
Deficient	0
At-Risk	0
Repeat Finding	0
Not Applicable	0

Facility Snapshot/Description

Port Isabel Detention Center (PIDC) is located in rural Los Fresnos, in the southern portion of the state of Texas, approximately 15 miles north of the Gulf of Mexico. The United States/Mexico border is approximately 22 miles south of PIDC. PIDC has a 350-acre footprint, comprised of 262 acres of developed land and 88 acres of undeveloped protected habitat for local wildlife. The facility houses low, medium and high custody adult male detainees and low security female detainees for ICE. The total rated capacity is 960. The population count during the inspection was 967 which included 663 male and 304 female detainees. The average length of stay is five days.

The Port Isabel Detention Center is a multi-storied, direct supervision facility. The four main housing units are two-story buildings, and each contains four housing pods with a capacity of 75 general population detainees per pod. There is a 14-bed segregation unit and a 35-bed infirmary. Detainees are afforded the opportunity for both indoor and outdoor recreation daily, and detainees were observed participating in both. Each dormitory has a large dayroom area equipped with tables, chairs, televisions, board games, laundry equipment, and microwaves, and an adjacent outdoor recreation area that has basketball hoops and workout stations. Each of the outdoor recreation areas are shared between two housing pods. There is also a large main outdoor recreation field that is scheduled for weekly use by all detainees. All detainees are forced to go to outdoor recreation for both the unit and main outdoor recreation periods. The entire facility is climate controlled. Telephones are available in the general population housing units and the recreation areas. Detainees have access to vending machines and are permitted to have $20.00 cash in their possession.

No less than 110 detainees were interviewed by the inspection team, and interviews indicated general satisfaction with the entire PIDC experience. In fact, no complaints were voiced to the inspectors. Detainees feel safe at the facility and claim that their needs are met. Confidential and LEP interviews revealed that detainees have no problems accessing services and are comfortable in this environment, inasmuch as one can be comfortable in a detention setting.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The facility presents as very clean and noise levels were minimal. Supervisors and officers exhibited a professional demeanor in both attire and attitude, and possessed a working knowledge of the standards as well as an understanding of the concepts of civil detention. Interactions between staff and ICE detainees were observed to be respectful and professional.

Medical services are provided by IHSC. There are no medical co-payments. Security is contracted to Ahtna STS. Ahtna STS subcontractors include: Trinity Group Services for commissary services; Superi-

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or Security LLC for quality assurance; and Asset Protection for transportation. Maintenance is provided by K Corp.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and no (0) standards were Not Applicable (N/A). All forty-two (42) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials - (b)(6); (b)(7)(C) and various other ICE supervisors and staff
- Facility Staff - (b)(6); (b)(7)(C) and various other supervisors and staff

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	February 2, 2017
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

January 31, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Port Isabel Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Port Isabel Service Processing Center in Los Fresnos, TX, during the period of January 29-31, 2019. This is a SPC.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a rating of Meets Standards during the January 2018 inspection.

Inspection Summary

The Port Isabel Service Processing Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 compliance annual inspections:

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2018 Inspection	
Meets Standards	42
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	0

2019 Inspection	
Meets Standards	42
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	0

The inspection team identified one (1) deficient component in the following one (1) standard:

Personal Hygiene - 1

Facility Snapshot/Description

The Port Isabel Detention Center is a Service Processing Center operated by ICE personnel and contract Ahtna security/detention personnel under the general oversight of the OIC, who is employed by ICE. The center is located in the tip of southern Texas near the Gulf of Mexico coast about 150 miles south of Corpus Christi and twenty miles north of the Mexico border. The center houses adult male and female ICE detainees of all classification levels. The center has an operational capacity of 1175 detainees. The average daily population of the facility during this inspection was 1038 of which 754 were male detainees and 284 were female detainees. The average length of stay for a detainee is ten days.

The center sits on a tract of 262 acres of native land in an isolated setting. The original physical plant was built in 1940; it was originally a U.S. Navy airfield. The center repurposed the land and its multiple remote buildings to serve as a detention facility. (b)(7)(E)

(b)(7)(E)

The center has four large housing units each divided into four separate dormitory wings, each with sixty beds. The center has one special management unit. It houses male and female segregation status detainees. The remainder of the buildings are used for administrative, support and program services. Travel distances between the buildings are lengthy. The center is maintaining an above average level of cleanliness and sanitation.

Indoor and outdoor recreation is available to all detainees. Detainees have access to televisions, board games, cards, library books and a microwave in the dayrooms. Telephones are provided in the dayrooms and are accessible during posted waking hours. Each housing unit has access to outdoor recreation which is available to all detainees for at least two hours each day. During the inspection, detainees were observed socializing in the dayrooms and recreating in the outdoor yard areas. Detainees have access to vending machines and are permitted to have $20.00 cash in their possession. There are microwaves in the housing units.

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Over forty LEP and English-speaking detainees were interviewed in either public or confidential settings. The language line was used during some of these encounters. Detainees were comfortable speaking with the inspectors and did not register any substantive complaints. The Ahtna detention personnel and ICE staff have frequent interaction with the detainees. Detainees voiced no pressing concerns and, when questioned, were satisfied with their living conditions, access to programs and activities and treatment by all staff. Observations of staff administering their shift duties revealed a polite and polished regulation of the daily schedule. Their interactions with the detainees was direct, calm and consummate. Detainees freely approached facility staff and the inspection team to converse.

Security services are contracted to Ahtna. Medical services are provided by IHSC. Detainees are not charged medical, dental or mental health co-pay fees.

Areas of Concern/Significant Observations

There were no areas of concern identified during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. All forty-two (42) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) and other department representatives
- Facility (Ahtna) Staff – (b)(6); (b)(7)(C) and other department representatives

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 31, 2019

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

January 30, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Port Isabel Service Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Port Isabel Service Processing Center in Los Fresnos, Texas during the period of January 28-30, 2020. This is an SPC.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2019 annual inspection.

Inspection Summary

The Port Isabel Service Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 PBNDS 2011 annual compliance inspections:

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2019 Annual Inspection	
Meets Standards	42
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	0

2020 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team identified three (3) deficient components in the following three (3) standards:

Environmental Health and Safety – 1
Tool Control – 1
Personal Hygiene - 1

Facility Snapshot/Description

The Port Isabel Service Processing Center is located in rural Los Fresnos, Texas, in the southern portion of the state, approximately 22 miles north of the U.S./Mexico border. The 1,200-bed facility is located on a 350-acre site; 262 acres of developed land and 88 acres of undeveloped native grounds that serve as a habitat for local wildlife. The facility houses male ICE detainees of all classification levels. The facility previously held female ICE detainees; however, there are no females housed at this time. The population count on the first day of the inspection was 1,055. The average length of stay was reported to be eleven days.

The direct supervision facility houses detainees in four main housing units. Each unit contains four 75-bed dorms for general population detainees. There is a fourteen-bed segregation unit and a 35-bed infirmary. Both indoor and outdoor recreation is offered. Detainees were observed participating in both. The facility has two soccer fields. Indoor recreation includes board games, cards, viewing television, and playing ping pong. Tablets are available in the housing units. Detainees may play games, watch movies or "face time" with family and friends on the tablets. Movies are shown in the recreation building. Inspectors observed numerous detainees attending the movies. Telephones are available in the housing units and recreation yards. Microwaves are available in the housing units as are vending machines.

The inspection team visited all areas of the facility. Sanitation was observed to be good in the common areas and housing units. It was noted that while the shower areas were clean, they are in need of maintenance. A few broken/cracked tiles and missing grout were observed. No mold or soap scum was noted.

Detainees were interviewed throughout the facility in groups or in a private, confidential setting. No less than fifty detainees were interviewed during the inspection. There were no issues or complaints. Fourteen LEP detainees from China, Somalia, Sri Lanka, and Latin American countries were interviewed using the telephonic translation service. All detainees stated that they felt safe at the facility and were treated well by the staff. One detainee from China stated that he had some difficulty understanding the orientation but that he had since been provided with information in Mandarin.

The inspection team visited the housing units' multiple times during the inspection. Detainees were relaxed and approached the inspectors without hesitation. It was noted that the detainees were familiar with the ICE officers and command staff. A review of the housing unit logs verified that supervisors make

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multiple rounds of the facility each day. Staff interaction with detainees was noted to be respectful and cordial and no issues were noted regarding the conditions of confinement.

Detainees are not charged co-pay fees for medical, dental or mental health services. Medical services are provided by IHSC. Security services are contracted to Ahtna.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standard and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility (Ahtna) Staff – (b)(6); (b)(7)(C) and various other department supervisors and administrative staff.

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 30, 2020

Printed Name of LCI Date

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The Nakamoto Group, Inc.

March 30, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Inspection of the South Texas Detention Complex**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the South Texas Detention Complex in Pearsall, Texas during the period of March 28-30, 2017. This is a CDF.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Security	(b)(6); (b)(7)(C)	
Detainee Rights		
Medical Care		
Safety		
QMC		

Type of Inspection

This is a scheduled annual inspection, which was performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a rating of Meets Standards during the March 2016 inspection.

Inspection Summary

The South Texas Detention Complex is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

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Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 annual compliance inspections:

2016 Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2017 Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

Facility Snapshot/Description

The South Texas Detention Complex is owned and operated by The GEO Group, Inc. The facility is located sixty miles south of San Antonio in Pearsall, TX. It has a rated capacity of 1904. The facility is a linear structure with all support services, administrative offices and housing units accessible off of one central quarter mile corridor (b)(7)(E)
(b)(7)(E)
(b)(7)(E) The facility houses only adult male and female ICE detainees of all custody levels. During the inspection, the average population was 1440 which included 129 female detainees. The average length of stay for a detainee is sixty days.

The facility has twenty-three general population housing units, all configured into dormitory settings ranging from 16 to 100 beds. The day rooms are furnished with a television, telephones, tables and open space. Each detainee has a personal property storage locker. The special management unit, a separate housing structure, has two levels with a total of 36 one-man cells. The atmosphere in the housing units was relaxed and detainees openly communicated with the inspection team. Each general population housing unit has direct access to an outdoor recreation area, which is available seven days a week.

Facility employees are experienced in their correctional tenures and highly professional in their daily conduct. Many staff members are bilingual. Staff interaction with detainees is frequent, quiet and respectful. Detainees were orderly throughout their daily movements and program/activity participation. The inspection team interviewed several LEP detainees publicly and privately in the housing unit, common areas and on work assignments. They registered no substantive complaints or concerns when questioned about their personal safety, treatment by staff, medical care, asylum requests, consulate/court access, ICE services, visiting privileges, law library access or food services.

Medical services are provided by IHSC. Over 100 medical records were reviewed. There are no medical co-payments. Food services are provided by GEO.

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Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of compliance and non-compliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C) and the on-site facility offices
- Facility Staff – Warden Ray Castro, (b)(6); (b)(7)(C) and various other command staff and department supervisors.

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector March 30, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

March 22, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the South Texas Detention Complex**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the South Texas Detention Complex in Pearsall, TX during the period of March 20-22, 2018. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Detainee Rights	(b)(6); (b)(7)(C)	
Security		
Medical Care		
Safety		
Medical Care		

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the March 2017 inspection.

Inspection Summary

The South Texas Detention Complex is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 annual compliance inspection:

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2017 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

Facility Snapshot/Description

The South Texas Detention Complex is owned and operated by The GEO Group, Inc. The facility is located sixty miles south of San Antonio in Pearsall, TX. It has a rated capacity of 1904. The facility only houses adult male and female ICE detainees of all custody levels. During the inspection the average population was 1774 which included 209 female detainees. The average length of stay for a detainee is sixty days.

The facility is a linear structure with all support services, administrative offices and housing units accessible off of one central quarter mile corridor.(b)(7)(E)

(b)(7)(E)

The facility has 22 general population housing units, all configured into dormitory settings ranging from 16 to 100 beds. The day rooms are furnished with televisions, telephones, tables with fixed seats and ample open space. Each detainee has a personal property storage locker. The special management unit has separate housing areas for males and females combining for a total of 181 beds configured into one and two bed cells.

The atmosphere in the housing units was relaxed. Detainees openly communicated with the inspection team and facility staff. Each general population housing unit has direct access to an outdoor recreation area, which is available seven days a week.

Facility employees are highly professional in their daily conduct and management techniques. Many staff members are bilingual. Staff interaction with detainees is frequent, easy and respectful. Detainees were orderly throughout their daily escorted movements and program/activity participation. The inspection team interviewed 74 English speaking and LEP detainees publicly and privately in the housing unit, common areas and on work assignments. They registered no substantive complaints or concerns when questioned about their personal safety, treatment by staff, medical care, asylum requests, consulate/court access, ICE services, visiting privileges, law library access or food services.

Medical services are provided by IHSC uniformed and contract personnel. There are no medical co-payments. Food and maintenance services are provided by GEO personnel. The facility maintains an above average level of cleanliness.

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Areas of Concern/Significant Observations

There were no areas of concern of significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials - (b)(6); (b)(7)(C)
- Facility Staff - Warden Ray Castro, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector	March 22, 2018
Printed Name of LCI	Date

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The Nakamoto Group, Inc.

February 28, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the South Texas Detention Complex**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the South Texas Detention Complex in Pearsall, TX during the period of February 26-28, 2019. This is a CDF.

The inspection was performed under the guidance of Jack T. Hartwig, Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member	
Safety	(b)(6); (b)(7)(C)	
Security		
Medical Care		
Detainee Rights		
Medical Care		

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the March 2018 inspection.

Inspection Summary

The South Texas Detention Complex is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual compliance inspection:

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2018 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

2019 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	2

The inspection team identified two (2) deficient components in the following two (2) standards:

Grievance System – 1
Staff-Detainee Communication – 1

Facility Snapshot/Description

The South Texas Detention Complex is owned and operated by The GEO Group, Inc. The facility is located sixty miles south of San Antonio in Pearsall, TX. It has a rated capacity of 1904. The facility only houses adult male and female ICE detainees of all custody levels. During the inspection, the average daily population was 1687 detainees. The average length of stay for a male detainee is 59 days and 53 days for a female detainee.

The facility is a linear structured building with all support services, administrative offices and housing units accessible off one long central corridor.(b)(7)(E)

(b)(7)(E)

The facility has 26 general population housing units configured into dormitory settings ranging from 64 to 100 beds. Five of the housing units were quarantined during the inspection due to a mumps outbreak. The day rooms are furnished with televisions, telephones, tables with fixed seats and ample open space. Each detainee has a personal property storage locker and is provided a combination lock at no charge. The special management unit is divided into two separate units; a 32-bed male unit at one end of the facility and an 18-bed female unit at the opposite end.

The atmosphere in the housing units was relaxed and muted. Detainees were communicative when approached by staff and they chatted freely with the inspectors. The inspection team interviewed several male and female detainees publicly and privately in segregation, the housing units, in intake, on work assignments and in the medical unit. There were 42 transgender detainees housed in the facility during the inspection, six were interviewed by the inspectors. Interviews were conducted with the assistance of bilingual staff and use of the language line. Throughout all detainee interviews no substantive complaints or concerns were registered when questioned about personal safety, treatment by staff, medical care, asylum requests, consulate/court access, ICE services, visiting privileges, law library access or food services. All detainees have access to indoor/outdoor recreation every day.

Security staff orchestrate the daily schedule in choreographed escorted line movements from housing units to program and activity sites. Most staff are bilingual and manage the demands of their posts with no sense of importunity.

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Medical services are provided by IHSC uniformed and contract personnel. There are no medical co-payments. Food and maintenance services are provided by GEO personnel. The facility maintains an above average level of cleanliness.

Areas of Concern/Significant Observations

There were no areas of concern of significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff - Warden Ray Castro, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
  other executive and administrative staff

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — February 28, 2019

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

February 27, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the South Texas ICE Processing Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the South Texas ICE Processing Center in Pearsall, Texas during the period of February 25-27, 2020. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the February 2019 inspection.

Inspection Summary

The South Texas ICE Processing Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 annual inspections:

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2019 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

2020 Annual Inspection	
Meets Standards	40
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	2

The inspection team found two (2) component deficiencies in the following two (2) standards:

Staff-Detainee Communication – 1, which is a repeat deficiency
Grievance System – 1, which was a repeat deficiency.

Facility Snapshot/Description

The South Texas ICE Processing Center is owned and operated by The GEO Group, Inc. (GEO). The facility is located sixty miles south of San Antonio in Pearsall, Texas. It has a rated capacity of 1800. The facility only houses adult male and female ICE detainees of all custody levels. During the inspection, the average daily population was 1,398 detainees. The average length of stay for a male detainee is 81 days and 93 days for a female detainee.

The facility is a linear structured building with all support services, administrative offices, and housing units accessible off one long central corridor. (b)(7)(E)

(b)(7)(E)

The facility has 26 general population housing units configured into dormitory settings ranging in size from 64 to 100 beds. Five of the housing units were empty during the inspection. The day rooms are furnished with televisions, telephones, tables with fixed seats, and ample open space. Each detainee has a personal property storage locker and is provided a combination lock at no charge. The special management unit (SMU) is divided into two separate units; a 36-bed male unit at one end of the facility and an eighteen-bed female unit at the opposite end. All general population detainees receive at least four hours of outdoor recreation daily. SMU detainees in administrative segregation status receive at least two hours of outdoor recreation seven days a week; and SMU detainees in disciplinary segregation status receive at least one hour of outdoor recreation five days a week.

The Talton (telephone contractor) electronic tablets have the capability to process grievances, detainee requests, and many other services, but the menu options and/or ability of the system does not allow for medical grievances to be directly submitted to medical staff. They simply go into a general grievance bin and when identified as a medical grievance they are forwarded to medical by a non-medical staff member. Detainee requests can be submitted electronically but the electronic log is not user friendly when retrieving and/or tracking adherence to the response requirements dictated by the standard.

The atmosphere in the housing units was relaxed and kept. Detainees were communicative when approached by staff and they chatted freely with the inspectors. The inspection team formally interviewed approximately 43 male and female detainees casually and privately in the housing units, in intake, on work assignments, in the medical unit, and in a private confidential setting. There were thirteen transgender detainees housed in the facility during the inspection; five were interviewed by the medical

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SME. All interviews were conducted with the assistance of bilingual staff, the use of the language line, or in English. Throughout all detainee interviews no substantive complaints or concerns were registered when questioned about personal safety, treatment by staff and other detainees, medical care, ICE contact, handbook information, law library access, or food services. Out of all the interviews two medical concerns rose to the level of further investigation. Both were followed up by the medical SME and revealed both concerns had been recently treated by health care staff and follow-up appointments were already scheduled. No further action was necessary. One detainee alleged he had not been seen by ICE/ERO staff in three years. The detainee rights SME discussed the statement with the detainee's deportation officer and the COR. Both individuals immediately knew of the detainee and stated he had been seen many, many times. The detainee is just impatiently awaiting action on the next level of his case review.

All movement is escorted. Most staff are bilingual and manage the demands of their posts with a thorough sense of certitude and thorough knowledge of the daily schedule and required responses to emergency situations.

Medical services are provided by a combined effort from IHSC uniformed staff and SDG International contract personnel. There are no medical copayments. Food and maintenance services are provided by GEO personnel. The facility maintains a very good level of sanitation and cleanliness.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and two (2) standards were Not Applicable (N/A). All remaining forty (40) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
- Facility Staff – Warden Ray Castro, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector February 27, 2020

Printed Name of LCI Date

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The Nakamoto Group, Inc.

May 4, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Stewart Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Stewart Detention Center, Lumpkin, GA during the period of May 2-4, 2017. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Security	(b)(6); (b)(7)(C)
Detainee Rights	
Medical Care	
Safety	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the April 2016 inspection.

Inspection Summary

The Stewart Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	3

2017 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	3

The inspection team did not identify any deficient components.

Facility Snapshot/Description

The Stewart Detention Center, a DIGSA facility, is owned and operated by CoreCivic, formerly known as Corrections Corporation of America (CCA). The facility is located in a rural community approximately 141 miles south of Atlanta. The facility houses low, medium, medium-high and high custody adult male detainees. The facility has 1924 beds. The population count on the first day of the inspection was 1874. The average length of stay for a detainee is 66 days.

The Stewart Detention Center was opened in 2006. The 297,550 square foot facility includes seven units, three of which are dormitory style consisting of six pods each. Three units are of cellblock (linear) design and include three pods. Three pods in each cellblock unit contain between 40-44 cells. The restrictive housing unit consists of two pods with 40 cells each. Direct supervision is provided during the first and second shifts. Third shift officers provide indirect supervision. Detainees are afforded both indoor and outdoor recreation. Each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks, and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise and video game systems and movies are available. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise areas.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. Supervisors and officers exhibited a professional demeanor in both attire and attitude. Interactions between officers and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC. Food service operations are provided via a contract with Trinity Services Group.

No less than 220 detainees were interviewed during the inspection. Interviews included LEP, detainees in administrative and disciplinary segregation, detainees in each housing unit, detainees working in food services, detainees participating in programs and services and confidential interviews. Detainee interviews yielded overall general satisfaction with living conditions, recreation, telephones, food services and medical care. Detainees did not express any concerns regarding life and/or safety issues. Cleanliness standards are average throughout the facility. During the inspection, 109 medical records were reviewed.

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Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Bill Spivey, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector May 4, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

May 3, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Stewart Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011 of the Stewart Detention Center, Lumpkin, GA during the period of May 1-3, 2018. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member	
Detainee Rights	(b)(6); (b)(7)(C)	
Security		
Medical Care		
Medical Care		
Safety		

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the May 2017 inspection.

Inspection Summary

The Stewart Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 annual inspections:

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2017 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

2018 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

The inspection team identified six (6) deficient components in the following four (4) standards:

Funds and Personal Property—1
Tool Control—1
Food Service—1
Law Libraries and Legal Material—3

Facility Snapshot/Description

The Stewart Detention Center is owned and operated by CoreCivic via a contract with Stewart County which has an IGSA with the Department of Homeland Security (ICE). The facility is physically located in Lumpkin, GA approximately 143 miles south of Atlanta. Construction on the facility began in 1999. The facility was subsequently acquired by the former Corrections Corporation of America (CCA) and was opened in 2006. The OIC reports an operational capacity of 1924 beds. The facility houses all custody levels of adult male ICE detainees.

The facility is a single level structure which contains six general population housing units; three of which contain dormitory beds in six pods and three contain cell housing in three pods. Additionally, the facility has a segregation management unit consisting of 39 single cells. A housing pod containing 80 beds is used for overflow. All housing units are provided direct supervision on each of the first two shifts; indirect supervision is provided on the overnight (third) shift. On the first day of the inspection the total population of the facility was 1863. The average daily population since the previous inspection in May 2017 was 1816 male detainees with an average length of stay of 56 days.

Detainees in both the general population and segregation management unit housing areas are afforded both indoor and outdoor recreation. In the general population units, each dormitory has a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks, and televisions. Board games, puzzles, playing cards, x-box gaming systems, exercise and video game systems and movies are available. A microwave oven is also provided. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise yards. Detainees may participate in the voluntary work program.

Overall, the team found the atmosphere in the facility to be calm with no obvious indicators of high stress. Facility staff was observed interacting with detainees; the interactions appeared to be professional and productive. Sanitation and cleanliness was observed to be average.

Numerous ICE detainees were interviewed during the course of the inspection, which included some interviews with detainees with limited English proficiency. Several interviews were in a group forum and some were private and confidential. The detainees voiced no concerns regarding life/safety issues. Detainees were generally satisfied with living conditions, food service, access to medical care and the responsiveness of facility and ICE staff.

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Two detainees complained about the use of a substitute milk product referred to as a dairy drink on the menu. Several other detainees voiced concerns about the lack of variety of food items on the menu. The lead compliance inspector and the safety SME followed up on these concerns. Detainees on special diets, to include religious diets, are provided milk. However, all other detainees receive a substitute milk product. The safety SME found that meals are prepared utilizing approved recipes and ingredients. The menus have been nutritionally analyzed, certified and approved by a registered dietitian. A review of the menus indicated that the ethnic diversity of the facility has been considered when the menus were developed.

Some detainees complained that ICE personnel do not visit their housing units on a regular basis. A review of the logbook which records visits by ICE staff, maintained in each housing unit, indicated that ICE personnel visit each housing unit at least weekly. The ICE compliance officer and unit management staff confirmed that ICE personnel routinely visit the housing units.

Medical care is provided by ICE Health Service Corp (IHSC). The facility does not charge copays for medical, mental health or dental care.

Detainee telephone services are provided via the national ICE contract with Talton Communications, Inc. Food service operations are provided via a contract with Trinity Services Group, Inc.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Charlie Peterson; (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	May 3, 2018
Printed Name of LCI		Date

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The Nakamoto Group, Inc.

May 9, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Stewart Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011 of the Stewart Detention Center, Lumpkin, Georgia during the period of May 7- 9, 2019. This is a dedicated IGSA (DIGSA) facility.

The annual inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the May 2018 inspection.

Inspection Summary

The Stewart Detention Center is currently accredited by:

- The American Correctional Association (ACA) – Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) – No
- Prison Rape Elimination Act (PREA) – Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 PBNDS 2011 annual inspections:

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2018 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

2019 Annual Inspection	
Meets Standards	39
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	3

The inspection team identified four (4) deficient components in the following four (4) standards:

Environmental Health and Safety - 1
Funds and Personal Property—1, which is a repeat deficiency
Tool Control—1
Detention Files - 1

Facility Snapshot/Description

The Stewart Detention Center is owned and operated by CoreCivic via a contract with Stewart County which has an IGSA with the Department of Homeland Security (ICE). The facility is located in Lumpkin, Georgia approximately 140 miles south of Atlanta. Construction on the facility began in 1999. The facility was subsequently acquired by the former Corrections Corporation of America (CCA) and was opened in 2006. The warden reports an operational capacity of 1924 beds. The facility houses adult male ICE detainees in all custody levels.

The facility is a single level structure containing six general population housing units, three of which contain dormitory beds in six pods and three contain cell housing in three pods. Additionally, the facility has a segregation management unit consisting of 39 single cells. An 80-bed housing pod is used for overflow. All housing units are provided direct supervision on each of the first two shifts; indirect supervision is provided on the night (third) shift. On the first day of the inspection the total population of the facility was 1874 detainees. The average length of stay is fifty days.

Detainees are afforded both indoor and outdoor recreation. Each dormitory contains a large dayroom area equipped with tables, chairs, telephone banks, commissary kiosks and televisions. Board games, puzzles, playing cards, exercise equipment, video game systems and movies are available. A microwave oven is also provided. Outdoor activities include pull-up and sit-up stations, volleyball, basketball, handball, soccer and walking in the exercise yards. Detainees may participate in the voluntary work program.

Overall, the team found the atmosphere in the facility to be calm with no obvious indicators of high stress. Facility staff were observed interacting with detainees. Interactions were observed to be professional and productive. Sanitation and cleanliness were observed to be average.

Approximately seventy-five detainees were interviewed and included detainees with limited English proficiency, detainees with disabilities, detainees in the recreation yard, detainees in the dining room and detainees in the special management unit. Confidential interviews were conducted. Interviews with LEP detainees were done with the InterpreTalk language line. Two detainees stated that their names were incorrectly spelled during the admission process. The unit manager provided immediate follow up. Two detainees complained that food portions are "too small". The safety SME found that meals are prepared utilizing approved recipes and ingredients. The menus have been nutritionally analyzed, certified and approved by a registered dietitian.

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Detainees voiced no concerns regarding life/safety issues. Detainees were generally satisfied with living conditions, food service, access to medical care, access to the law library, visitation privileges and the responsiveness of facility and ICE staff.

During this inspection period, medical care was provided by ICE Health Service Corp (IHSC) from May 4, 2018 through November 10, 2018. On November 11, 2018, CoreCivic Medical took over the health care responsibilities. The facility does not charge copayments for medical, mental health or dental care.

Food service operations are provided via a contract with Trinity Services Group, Inc. All other services are provided by CoreCivic.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and three (3) standards were Not Applicable (N/A). All remaining thirty-nine (39) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Michael Donahue, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector May 9, 2019

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 26, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otay Mesa Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otay Mesa Detention Facility in San Diego, CA during the period of January 24-26, 2017. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Safety	
Medical Care	
QMC	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2016 inspection.

Inspection Summary

The Otay Mesa Detention Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 pre-occupancy inspection and the 2017 annual compliance inspection:

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2016 Pre-Occupancy Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

Facility Snapshot/Description

The Otay Mesa Detention Facility is a newly constructed 350,000 square foot medium-maximum security facility owned and operated by CoreCivic, formerly Corrections Corporation of America (CCA), under contract with Immigration and Customs Enforcement (ICE). The facility is located approximately four miles from the Otay Mesa U.S./Mexico border crossing. The facility began admitting ICE detainees on October 16, 2015.

The facility houses adult male and female ICE and U.S. Marshals Service detainees. On January 26, 2017, the total facility count was 1572, of which 1162 were ICE detainees. There were 1020 male and 142 female ICE detainees. The average length of stay for an ICE detainee is 36 days. The facility houses all classification levels of ICE detainees.

(b)(7)(E)

(b)(7)(E) There are fourteen separate housing unit configurations ranging from three separate segregation units designed as two-bed cells, to eleven 64-128 bed dormitories. Detainees in the housing areas are under the direct supervision of assigned housing unit officers and under constant camera surveillance. Detainees are provided with the opportunity to use their time socializing in the dayrooms, watching television, working or participating in indoor/outdoor recreation. Each general population housing unit has an adjacent outdoor recreation area. Detainees are allowed access to the housing unit outdoor recreation area during out of cell time, excluding meal service and count. In addition, on a weekly basis detainees are given access to a soccer field and a gymnasium.

All detainees interviewed stated that they felt safe and there were no issues or concerns expressed. Interviews included: detainees with special needs and limited English proficiency; males and females; detainees housed in general population and the special management unit; new admissions, and a detainee processed for release. Detainees were knowledgeable about the programs and services available. LEP detainees indicated that they had no issues communicating with staff and no problems obtaining services. All the detainees interviewed knew how to contact their assigned ICE officer.

The facility is clean with high sanitation standards.

The facility workforce is professional and knowledgeable of the ICE standards' requirements. Medical services are provided by IHSC and food services are provided by Trinity Services Group. All other services are provided by CoreCevic employees. ICE detainees do not incur medical co-payments.

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Areas of Concern/Significant Observations

There were no deficient components identified by the inspection team.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. Forty-one (41) standards were found to Meet Standards. One (1) standard is Not Applicable.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff - Warden Fred Figueroa, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 26, 2017

Printed Name of LCI Date

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AMERICAN OVERSIGHT

The Nakamoto Group, Inc.

January 25, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otay Mesa Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otay Mesa Detention Facility in San Diego, CA during the period of January 23-25, 2018. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Safety	
Medical Care	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2017 inspection.

Inspection Summary

The Otay Mesa Detention Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 annual compliance inspection:

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2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

Facility Snapshot/Description

The Otay Mesa Detention Facility is privately owned and operated by CoreCivic under contract with Immigration and Customs Enforcement (ICE). The facility is located on the southeastern outskirts of San Diego, CA, a short distance from Tijuana, Mexico. The facility houses adult male and female ICE and U.S. Marshals Service detainees of all security levels under the direct supervision model. During the inspection, the total count was 1424, including 821 male and 139 female ICE detainees. The average length of stay for an ICE detainee is 110 days.

(b)(7)(E)

(b)(7)(E) Detainees spend the majority of their time socializing in the dayrooms, watching television, working, or participating in indoor and outdoor recreation. Detainees enjoy optimal recreational opportunities, as each general population housing unit has an adjacent outdoor recreation area which detainees may use during the majority of their waking hours. Additionally, detainees are given access to a soccer field and a gymnasium no less than weekly. The facility offers a wide variety of social and self-help programs to ICE detainees, as well.

Without exception, detainees stated that they felt safe at this facility. LEP interviews indicated that they have no issues accessing services or communicating with staff. All the detainees interviewed knew how to contact their assigned ICE officer. Two detainees complained that applesauce is served every time fruit is on the menu. The Safety SME reviewed the menu and determined that applesauce is the only fruit item served. The facility is now considering adding other fruit items, such as fruit cocktail and pineapple, to the menu. Two detainees complained of medical issues. One detainee claimed that he could not get a walker from the medical department. It was determined that the detainee had a walker, issued by the medical department, in his living area. Ultimately, the detainee admitted that he wanted to order his own personal walker because he did not like the walker that the medical department had issued to him. He then complained that it would take too long to arrive if he ordered his own walker. He also stated that he wanted physical therapy. His medical record indicated that he was being scheduled for physical therapy. Another detainee stated that he had undergone hernia surgery while at the facility, and was having complications. A review of his medical record indicated that he had been to outside specialty doctors on no less than twenty occasions, but was not happy with the options presented to him to address the complications. One detainee complained that he could not get approval to exclude his conversations with a family member on the telephone from being recorded. He claimed that as a pro se detainee, his conversations with his family about his case were protected and should not be recorded. The facility explained that they did in

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fact deny the request, as the detainee is not an attorney and therefore did not have the right to unrecorded conversations with his family.

Two detainees complained that the telephones did not lend themselves to a reasonable amount of privacy. In every unit, at least one telephone is located in an isolated area. Further, requests for confidential calls in the privacy of the unit team offices are liberally granted. No less than 115 detainees were interviewed by the inspection team.

Employees were professional in appearance and demeanor, and many displayed some knowledge of the standards. A majority of the employees are bilingual.

There were fifty-six physical responses to detainee resistance during the inspection period, as opposed to eighteen during the previous inspection period. ICE explained this discrepancy as being due to the large increase of detainees with serious mental illness in the facility. As most of the incidents involved minor interaction for redirection and non-routine application of restraints, the explanation is reasonable.

Medical services are provided by IHSC and food services are provided by Trinity Services Group. All other services are provided by CoreCivic employees. ICE detainees do not incur medical co-payments.

Areas of Concern/Significant Observations

Of significance is the fact that there were no deficient components identified by the inspection team.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. Forty-one (41) standards were found to Meet Standards. One (1) standard is Not Applicable.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff - (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector January 25, 2018

Printed Name of LCI Date

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The Nakamoto Group, Inc.

January 25, 2019

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otay Mesa Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Otay Mesa Detention Facility in San Diego, CA during the period of January 23-25, 2019. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Safety	
Medical Care	
Medical Care	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2018 inspection.

Inspection Summary

The Otay Mesa Detention Facility is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2018 and 2019 annual compliance inspection:

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2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

Facility Snapshot/Description

The Otay Mesa Detention Facility is privately owned and operated by CoreCivic under contract with Immigration and Customs Enforcement (ICE). The facility is located about 25 miles South of San Diego, CA on the border of Mexico. The facility houses adult male and female ICE and U.S. Marshals Service detainees of all classification levels. The facility has an operational capacity of 1572 detainees. The average daily population of the facility during this inspection was 1458, of which 933 were ICE detainees. The average length of stay for an ICE detainee is 69 days.

The physical plant was built in 2015. The facility has fifteen general population housing units, of which eleven are dedicated to ICE detainees. Nine of the housing units are for general population. The remaining two housing units are segregation blocks; one 32 cell unit with two beds in each for males, and one six cell unit with two beds in each for females. ICE detainees neither mingle nor are they housed with non-ICE detainees.

(b)(7)(E)

Detainees have access to televisions, board games, cards, library books and a microwave in the dayrooms. Telephones are provided in the dayrooms. Each housing unit has direct access to outdoor recreation which is available to all detainees for at least two hours each day. During the inspection, detainees were observed socializing in the dayrooms and recreating in the outdoor yard areas. Conditions of confinement were orderly and the facility is kept in an exceptional level of cleanliness. Detainees were engaging with the inspectors during their frequent tours through the housing units. The staff and ICE personnel interactions with the detainees carried no sense of uncertainty and the detainees' responses to these encounters appeared contented. Detainees freely approached facility staff and the inspection team to converse.

The inspection team visited the housing units several times to interview all detainees wishing to speak to them. Inspectors conducted seven confidential LEP detainee interviews using the language line and on-site bi-lingual staff, in excess of sixty interviews, with English/Spanish speaking detainees in the housing units and common areas and formal interviews with six transgender detainees. None of the detainees voiced any substantive concerns regarding their safety, conditions of confinement, meals, medical care, treatment by staff, access to ICE personnel or the availability of activities and programs.

Medical services are provided by IHSC and food services are provided by Trinity Services. All other services are provided by CoreCivic employees. ICE detainees do not incur medical co-payments.

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Areas of Concern/Significant Observations

There were no areas of concern or significant observations identified during this inspection.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. Forty-one (41) standards were found to Meet Standards. One (1) standard is Not Applicable.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — January 25, 2019

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

January 24, 2020

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Otay Mesa Detention Facility**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS 2011) of the Otay Mesa Detention Facility in San Diego, California, during the period of January 22-24, 2020. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Safety	
Medical Care	

Type of Inspection

This is a scheduled annual inspection which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the January 2019 inspection.

Inspection Summary

The Otay Mesa Detention Facility Jail is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) – Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2019 and 2020 annual inspections:

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2019 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2020 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

The inspection team found two (2) component deficiencies in the following two (2) standards:

Environmental Health and Safety – 1
Staff- Detainee Communication – 1

Facility Snapshot/Description

The Otay Mesa Detention Facility is privately owned and operated by CoreCivic under contract with Immigration and Customs Enforcement (ICE). The facility is located about 25 miles South of San Diego, California, on the border of Mexico. The facility houses adult male and female ICE and U.S. Marshals Service detainees of all classification levels. The facility has a rated capacity of 1,970 beds. The average daily population of the facility during this inspection was 1,4222 of which 951 were ICE detainees. The average length of stay for an ICE detainee is 84 days.

The physical plant was built in 2015. It is a two-story building that houses the detention center and all of its support services network, ICE/ERO offices, five court rooms, and multiple attorney visiting rooms. The facility has seventeen general population housing units of which twelve are dedicated to ICE detainees. The ICE housing units are all configured into four to eight-bed bays divided into a two-tier wing. There are two special management units which house all populations; one 64-bed unit for males and one twelve-bed unit for females. General population ICE detainees are not housed with non-ICE detainees.

(b)(7)(E)

Detainees have access to televisions, board games, cards, library books, and a microwave in the dayrooms. Telephones are provided in the dayrooms for detainee use. Each general population housing unit has direct access to outdoor recreation which is available to all detainees for at least two hours each day. During the inspection, detainees were observed socializing in the dayrooms and recreating in the outdoor yard areas. Conditions of confinement were orderly and the facility is maintaining a high level of sanitation. Detainees were freely engaging with the inspectors and staff during the frequent tours conducted during this inspection. Staff and ICE/ERO personnel interactions with the detainees carried no sense of uncertainty and the detainees' responses to these encounters appeared contented and respectful.

The inspection team conducted casual interviews with the detainees in the housing units, on work assignment and in the health care unit; and several confidential interviews with LEP detainees and two transgender detainees using the language line. None of the detainees voiced any substantive concerns regarding their safety, conditions of confinement, meals, medical care, treatment by staff, access to ICE personnel, or the availability of activities and programs.

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Medical services are provided by IHSC staff and two independent medical contract groups. Food services are provided by Trinity Services. All other services are provided by CoreCivic employees. ICE detainees do not incur medical co-payments.

Areas of Concern/Significant Observations

There were no areas of concern or significant observations.

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance-Based National Detention Standards (PBNDS 2011). No (0) standards were found Deficient and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to be in compliance.

LCI Assurance Statement

The findings of compliance and noncompliance are accurately and completely documented on the G-324A Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility Staff – Warden Christopher LaRose, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector — January 24, 2020

Printed Name of LCI — Date

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The Nakamoto Group, Inc.

April 20, 2017

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Northwest Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Northwest Detention Center, Tacoma, WA during the period of April 18-20, 2017. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
QMC	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the April 2016 inspection.

Inspection Summary

The Northwest Detention Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - No

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2016 and 2017 PBNDS 2011 compliance annual inspections:

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2016 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Finding	0
Not Applicable	1

2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
At Risk	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified two (2) deficient components in the following two (2) standards:

Funds and Personal Property—1, which is a repeat deficiency
Recreation—1, which is a priority component

Facility Snapshot/Description

The Northwest Detention Center, a CDF, is owned and operated by the GEO Group, Inc. The facility is located in Tacoma, WA in a primarily industrial area approximately 25 miles south of the Sea-Tac International Airport, Seattle, WA. The facility houses all custody levels of male and female ICE detainees. The facility has a rated capacity of 1575. The population count on the first day of the inspection was 1295. The average length of stay for the previous twelve months was 79 days with an average daily population of 1435.

The Northwest Detention Center was constructed in 2004. In 2010, additional capacity was added to the facility. There are currently no plans for future construction or renovation. The administration building and the additional housing units constructed in 2010 are two levels; all other areas of the facility are single level. There are six general population housing units; four of the housing units each contain three housing pods and two of the housing units each contain four housing pods. Capacities of the housing units range from 205-278 beds. Both dormitory beds and cell housing is available at the facility. Dorm capacities range from 64-80 beds. Additionally, there are forty cells, each containing two beds, in the segregation management unit designated for males. All housing units are provided direct supervision around the clock. Detainees are afforded the opportunity for both indoor and outdoor recreation and were observed participating in both areas. Each housing unit has a large dayroom area equipped with tables, chairs, televisions, board games, ping pong tables, exercise equipment and microwaves. The entire facility is climate controlled. Telephones are available in the general population housing units at an optimal ratio of one telephone for every ten detainees. Detainees are issued color-coded uniforms and wristbands according to custody level.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. During the inspection sanitation at the facility was observed to be above average and noise levels were minimal. All facility and ICE staff encountered by the inspection team exhibited a professional demeanor. Interactions between staff and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Health services are provided by IHSC.

During the inspection, the Medical SME and QMC SME reviewed 123 medical files. Combined, all of the SMEs interviewed no less than fifty detainees which included detainees housed in the general population and in the segregation management units. Some interviews were confidential and included de-

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tainees who had limited English proficiency. Detainees' statements indicated general satisfaction with living conditions and with access to the law library, command staff, ICE personnel, telephones, medical care and translation services when needed.

One detainee stated that he was aware of a problem with foot fungus at the facility due to unsanitary shower conditions. The Security SME and the Medical SME followed-up on this complaint. The showers were observed to be very clean and sanitary and the medical department had no knowledge or record of any issues regarding foot fungus. Another detainee complained of lack of diversity in menu offerings. However, the safety SME reviewed the menu and observed meals during the inspection and found that the menu offerings meet the requirements of the standard. Additionally, the menu has been certified by a registered dietitian as exceeding minimum daily nutritional requirements.

Areas of Concern/Significant Observations

The inspection team identified one (1) deficient priority component:

Recreation
Component #5—All facilities shall have an individual responsible for the development and oversight of the recreation program. Every facility with a rated capacity of 350 or more detainees shall employ a full-time recreation specialist with special training in implementing and overseeing a recreation program, who assesses the needs and interests of the detainees.

Finding: The facility has a rated capacity of 1575. The total facility population on the first day of the inspection was 1295. The average daily population for the previous twelve months was 1435. The full-time recreation specialist position was eliminated since the previous annual inspection. The duties of the full-time recreation specialist have been assigned to the law library supervisor as collateral duties.

Recommendation: (b)(5)
(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

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- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility (GEO) Staff – Warden Lowell Clark (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Lead Compliance Inspector April 20, 2017

Printed Name of LCI Date

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The Nakamoto Group, Inc.

April 19, 2018

TO: Tae D. Johnson
Assistant Director for Detention Management

FROM: (b)(6); (b)(7)(C)
Lead Compliance Inspector
The Nakamoto Group, Inc.

SUBJECT: **Annual Detention Inspection of the Northwest Detention Center**

The Nakamoto Group, Inc. performed an annual inspection for compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011 of the Northwest Detention Center, Tacoma, Washington during the period of April 17-19, 2018. This is a CDF.

The inspection was performed under the guidance of (b)(6); (b)(7)(C) Lead Compliance Inspector. Team Members were:

Subject Matter Field	Team Member
Detainee Rights	(b)(6); (b)(7)(C)
Security	
Medical Care	
Medical Care	
Safety	

Type of Inspection

This is a scheduled annual inspection, which is performed to determine overall compliance with the ICE PBNDS 2011 for Over 72 hour facilities. The facility received a previous rating of Meets Standards during the April 2017 inspection.

Inspection Summary

The Northwest Detention Center is currently accredited by:

- The American Correctional Association (ACA) - Yes
- The National Commission on Correctional Health Care (NCCHC) - Yes
- The Joint Commission (TJC) - No
- Prison Rape Elimination Act (PREA) - Yes

Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the 2017 and 2018 PBNDS 2011 compliance annual inspections:

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2017 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Finding	0
Not Applicable	1

2018 Annual Inspection	
Meets Standards	41
Does Not Meet Standards	0
Repeat Deficiency	0
Not Applicable	1

The inspection team identified two (2) deficient components in the following two (2) standards:

Funds and Personal Property—1, which is a repeat deficiency
Recreation—1, which is a repeat priority component deficiency

Facility Snapshot/Description

The Northwest Detention Center (NWDC), a CDF, is owned and operated by the GEO Group, Inc. The facility is located in Tacoma, Washington in an industrial area approximately twenty-five miles south of Sea-Tac International Airport. The facility houses all custody levels of male and female detainees. The facility has a rated capacity of 1575. The population count on the first day of the inspection was 1389, which included 126 females and 1263 males. The facility reported an average length of stay for the previous twelve months as eighty-one days.

The Northwest Detention Center was constructed in 2004. In 2010, additional capacity was added to the facility. There are currently no plans for future construction or renovation. The administration building and the additional housing units constructed in 2010 are two levels; all other areas of the facility are single level. There are six general population housing units; four of the housing units contain three housing pods and two of the housing units contain four housing pods. Capacities of the housing units range from 205-278 beds. Both dormitory and cell housing is available at the facility. Dorm capacities range from 64-80 beds. Additionally, there are forty cells, each containing two beds, in the segregation management unit designated for males. Housing units are provided direct supervision around-the-clock. Detainees are afforded the opportunity for both indoor and outdoor recreation and were observed participating in both areas. Each housing unit has a large dayroom area equipped with tables, chairs, televisions, board games, ping pong tables, exercise equipment and microwaves. The entire facility is climate controlled.

The inspection team found the atmosphere to be calm with no obvious indicators of high stress levels. The sanitation levels were observed to be above average. Noise levels were minimal. Facility and ICE staff exhibited professional demeanor. Interactions between staff and detainees were observed to be respectful and professional.

The facility does not charge co-pays for medical, mental health or dental care. Medical and mental health services are provided by ICE Health Service Corp.

No less than seventy-five detainees were interviewed. Detainee statements indicated overall satisfaction with living conditions, access to the law library, telephones, medical care and translation services. Without exception, detainees stated that “they feel safe” and that "officers are respectful".

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Several detainees mentioned that beans are served "all the time". The safety SME reviewed the menu and observed meals during the inspection and found that the menu offerings meet the requirements of the standard.

Areas of Concern/Significant Observations

The inspection team identified one (1) repeat deficient priority component:

Recreation
Component #5—All facilities shall have an individual responsible for the development and oversight of the recreation program. Every facility with a rated capacity of 350 or more detainees shall employ a full-time recreation specialist with special training in implementing and overseeing a recreation program, who assesses the needs and interests of the detainees.

Finding: The facility has a rated capacity of 1575. The total facility population on the first day of the inspection was 1389. The average daily population for the previous twelve months was 1383. The full-time recreation specialist position was eliminated from the staffing plan in December 2016. The duties of the full-time recreation specialist have been assigned to the law library coordinator as collateral duties.

Recommendation: (b)(5)
(b)(5)

Recommended Rating and Justification

The Lead Compliance Inspector recommends that the facility receive a rating of Meets Standards. The facility complies with the ICE Performance Based National Detention Standards (PBNDS) 2011. No (0) standards were found Does Not Meet Standards and one (1) standard was Not Applicable (N/A). All remaining forty-one (41) standards were found to Meet Standards.

LCI Assurance Statement

The findings of Meets Standards and Does Not Meet Standards are accurately and completely documented on the G-324 Inspection Form and are supported by documentation in the inspection file. An out brief was conducted at the facility and in addition to the entire Nakamoto Group, Inc. Inspection Team, the following were present:

- ICE Officials – (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)
- Facility (GEO) Staff – Warden Lowell Clark, (b)(6); (b)(7)(C)
  (b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)	Lead Compliance Inspector	April 19, 2018
Printed Name of LCI		Date

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Documents Uploaded by (b)(6); (b)(7)(C)

IHSC-staffed Facilities:

Stewart:

2018 NCCHC report from when IHSC had a presence at the facility

2018 ACA report from when IHSC had a presence at the facility

2017 and 2018 PBNDS reports from when IHSC had a presence at the facility; 2019 PBNDS report (after IHSC ceased to have a presence there and CoreCivic took over medical care)

Pearsall:

2018 NCCHC report

2019 ACA report

2017-2020 PBNDS reports

Tacoma:

2018 NCCHC report

2017 ACA report

2017-2019 PBNDS reports

Eloy:

2018 NCCHC report

2018 ACA report

2017-2020 PBNDS reports

Jena:

2017 NCCHC report

2017 ACA report

2017-2019 PBNDS reports

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Port Isabel:

2019 NCCHC report

2017 ACA report

2017; 2019-2020 PBNDS reports

San Diego:

2018 NCCHC report

2019 ACA report

2017-2020 PBNDS reports

Houston:

2018 NCCHC report

2019 ACA report

2017-2020 PBNDS reports

El Paso:

2017 NCCHC report

2018 ACA report

2017-2019 PBNDS reports

Non-IHSC staffed facilities:

Adelanto:

For Adelanto East and Adelanto West:

2017-2019 PBNDS reports

Otero:

2017- 2020 PBNDS reports

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Joe Corley:

Only documents discovered on ICE SharePoint for 2017 and 2018 were RA memos and AOR-HOU messages. No reports (cover letter documents) located for this facility. No 2019 or 2020 data located.

Cibola:

2017-2019 PBNDS reports

Imperial:

2017-2020 PBNDS reports

Rio Grande:

2017-2019 PBNDS reports

Aurora:

2017-2019 PBNDS reports

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DENTAL CARE

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001713

CHRONIC DISEASE – DIABETES

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? BOP

Item # Measure

1. Was blood sugar measured and recorded on intake?
2. Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3. Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4. Were lipids measured within one year?
5. Was patient followed at least every 90 days with appropriate vital signs?
6. Was aspirin prescribed, as clinically indicated?*
7. Was degree of control (goal GgbA1C<8.0) documented?
8. Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES	NA	NA	NA
2		YES	YES	YES	YES	YES	NA	YES	YES
3		YES	YES	YES	YES	YES	NA	YES	YES
4		YES	YES	YES	NA	YES	NA	YES	YES
5		YES	YES	YES	NA	YES	NA	YES	YES
6		YES	NA	NA	NA	NA	NA	NA	NA
7		YES	YES	NA	NA	NA	NA	NA	NA
8		YES	YES	NA	NA	NA	NA	NA	NA
9		YES	YES	YES	NA	NA	NA	NA	NA
10		YES	YES	NA	NA	NA	NA	NA	NA
	Total	10/10 100%	9/9 100%	6/6 100%	3/3 100%	5/5 100%	n/a Na%	4/4 100%	4/4 100%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1 Was there a documented time urgency included on the order for specialty care or diagnostic services?
2 Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3 Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4 Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	YES	YES	N/A	YES
2		Other	YES	YES	N/A	YES
3		Cardiology	YES	YES	N/A	YES
4		Other	YES	YES	N/A	YES
5		Orthopedics	YES	YES	N/A	YES
6		Orthopedics	YES	YES	N/A	YES
7		Other	YES	YES	N/A	YES
8		Other	YES	YES	N/A	YES
9		Other	YES	YES	N/A	YES
10		Infectious Disease	YES	YES	N/A	YES
		Total	10 / 10 100%	10 / 10 100%	n / a NaN%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Cellulitis	YES	NO	YES	YES	YES
2		Abdominal Pain	YES	NO	YES	YES	YES
3		Syncope	YES	NO	YES	YES	YES
4		Drug Withdrawal	YES	NO	YES	YES	YES
5		Urinary Retention	YES	NO	YES	YES	YES
6		Abdominal Pain	YES	NO	YES	YES	YES
7		Vomiting Blood	YES	NO	YES	YES	YES
8		Abdominal Pain	YES	NO	YES	YES	YES
9		Kidney Stone	YES	NO	YES	YES	YES
10		Dehydration	YES	NO	YES	YES	YES
			10 / 10 100 %	0 / 10 0 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001716

HEALTH ASSESSMENT

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #		1	2	3	4	5
1	(b)(6); (b)(7)(C)		YES	YES	NA	YES	YES
2			YES	YES	YES	YES	YES
3			YES	YES	NA	YES	YES
4			YES	YES	NA	YES	YES
5			YES	YES	NA	YES	YES
6			YES	YES	NA	YES	YES
7			YES	YES	NA	NA	YES
8			YES	YES	NA	NA	YES
9			YES	YES	NA	YES	YES
10			YES	YES	NA	NA	YES
	Total		/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	NA	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	NA	YES
	Total	20 / 20 100 %	20 / 20 100 %	2 / 2 100 %	12 / 12 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP

Item #	Measure
1	How was HIV status identified? By laboratory, prior medical records or patient report?
2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4	Was antiretroviral treatment considered and documented?
5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Medical Record	NA	NA	YES	YES	YES
2		Medical Record	YES	NA	YES	YES	YES
3		Medical Record	YES	NA	NA	YES	YES
4		Medical Record	NA	NA	YES	YES	YES
5		Medical Record	YES	NA	YES	YES	YES
6		Medical Record	YES	YES	YES	YES	YES
7		Medical Record	YES	YES	YES	YES	YES
8		Medical Record	YES	YES	YES	YES	YES
9		Medical Record	YES	NA	YES	YES	YES
10		Medical Record	YES	YES	NA	YES	YES
	Total		8 / 8 100 %	4 / 4 100 %	8 / 8 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001719

CHRONIC DISEASE – HYPERTENSION

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? BOP

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	N/A	YES
2		YES	YES	N/A	YES
3		YES	YES	YES	YES
4		YES	YES	N/A	YES
5		YES	YES	N/A	YES
6		YES	YES	YES	YES
7		YES	YES	N/A	YES
8		YES	N/A	N/A	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	10 / 10 100 %	9 / 9 100 %	2 / 2 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

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LABORATORY TESTING

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NA
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001721

MEDICAL RECORDKEEPING PRACTICES

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☑ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	Compliant	NA	Compliant	NA
Special needs treatment plan, where applicable	NA	NA	Compliant	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☑ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	Compliant	NA	Compliant
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	Compliant	NA	Compliant	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	Compliant
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? NO

2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?

3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?

4 Estimate the percentage of patients on self-administered medication ordered by a provider. 10

5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?

2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?

3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		1	NA	NA
4		3	NA	NA
5		0	NA	NA
6		0	NA	NA
7		0	NA	NA
8		0	NA	NA
9		3	NA	NA
10		1	NA	NA
	Total		n /a Na%%	n /a Na%%

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # **Measure**

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #		1
1	(b)(6); (b)(7)(C)		YES
2			YES
3			YES
4			YES
5			YES
6			YES
7			YES
8			YES
9			YES
10			YES
	Total		10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

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DHS-ICE-20-0618-A-001726

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Otero County Processing Center			
AOR:*	ELP			
Address:	26 McGregor Range Road			
City:	Chaparral		**County:**	Dona Ana
State:*	NM	**Zip:**		88081
Inspection Information				
Start Date:*	4/5/2019			
End Date:*	4/8/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		1035		
Total Facility Population at Time of Visit:		1035		
Facility Capacity:		1089		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	4/25/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	80%	
CG	Complaints and Grievance	10	*Total Number
CM	Continuity of Medications	95%	
DC	Dental Care	100%	
DM	Diabetes	94%	
DSA	Diagnostic Services and Specialty Care Access	90%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	94%	
HIV	Human Immunodeficiency Virus	100%	
HTN	Hypertension	83%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	80%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder	97%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	71%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX	
**1 FTE = 40 hours / per week*	
Position	(b)(7)(E)
C.N.A.	
Dental Assistant	
Dentist	
EMT	
H.S.A.	
LVN/LPN	
MH Counselor	
MRT	
NP/PA	
Nurse Manager	
Paramedic	
Pharmacist	
Pharmacy Tech	
Physician	
Psychiatrist	
Psychologist	
RN	
Social Worker	
X-ray Tech	
Other 1 (Admin Clerk)	
Other 2 (Rad Tech/Clerk)	
TOTAL	

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs (Medical Administrative Record).					
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019	
Facility (f)						
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y	
fASM-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cASM-2	Was a peak flow completed at the initial physical exam?					
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?					
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.					
Total Applicable:		10	10	10	10	
Total Met:		2	10	10	10	
% Compliance:	80%	20%	100%	100%	100%	

Patient(s)	A# (numbers only)	cASM-1	cASM-2	cASM-3	cASM-4
1	(b)(6); (b)(7)(C)	No	Yes	Yes	Yes
2		No	Yes	Yes	Yes
3		No	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes
5		No	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes
7		No	Yes	Yes	Yes
8		No	Yes	Yes	Yes
9		No	Yes	Yes	Yes
10		No	Yes	Yes	Yes

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 4/5/2019

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP

	Clinical (c)
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		10	10	9	9	2	1	9	9
Total Met:		10	5	9	9	2	1	9	9
% Compliance:	94%	100%	50%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
2		Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
3		Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
4		Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
7		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes	
8		Yes	No	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS	
9		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes	
10		Yes	No	Yes	Yes	N/A - LOS	Yes	Yes	Yes	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines http://nccc.ucsf.edu						
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	4/5/2019			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			10	6	10	10	10
Total Met:			10	6	10	10	10
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Medical Record	Yes	Yes	Yes	Yes	Yes	
2		Medical Record	Yes	Yes	Yes	Yes	Yes	
3		Medical Record	Yes	N/A - LOS	Yes	Yes	Yes	
4		Medical Record	Yes	Yes	Yes	Yes	Yes	
5		Medical Record	Yes	N/A - LOS	Yes	Yes	Yes	
6		Medical Record	Yes	Yes	Yes	Yes	Yes	
7		Medical Record	Yes	Yes	Yes	Yes	Yes	
8		Medical Record	Yes	N/A - LOS	Yes	Yes	Yes	
9		Recent Lab	Yes	Yes	Yes	Yes	Yes	
10		Medical Record	Yes	N/A - LOS	Yes	Yes	Yes	

AMERICAN OVERSIGHT

HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	5	10	
Total Met:		10	3	5	10	
% Compliance:	83%	100%	30%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	No	Yes	Yes
2		Y	Yes	Yes	Yes
3		Y	Yes	Yes	Yes
4		Y	No	N/A - NLOS	Yes
5		Y	Yes	N/A - NLOS	Yes
6		Y	No	N/A - NLOS	Yes
7		Y	No	Yes	Yes
8		Y	No	Yes	Yes
9		Y	No	N/A - NLOS	Yes
10		Y	No	N/A - NLOS	Yes

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~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	7					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	1--not been ther for 3 months. 5. denied any medical problems on arrival or during PE					
Reviewer:	Type Text Here		**Date Reviewed:**	Select		
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	Type Text Here				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					

Total Applicable:		7	6	5	7	7
Total Met:		7	5	5	7	7
% Compliance:	97%	100%	83%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	N/A - NLOS	Yes	Yes	Yes
6		Yes	Yes	N/A - NLOS	Yes	Yes
7		Yes	No	Yes	Yes	Yes
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:	1, gastritis, meds not ordered until 4 days after arrival		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	4/5/2019

Clinical (c)	
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
cCM-2	Period of time from order to first dose less than 24 hours?

Total Applicable:		10	10
Total Met:		9	10
% Compliance:	95%	90%	100%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	No	Yes
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

AMERICAN OVERSIGHT

DENTAL CARE						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess compliance with detention standards and continuity of care.					
Source:	Dental sick call list or dental referral log.					
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.					
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019	
Clinical (c)						
cDC-1	Was patient screened for symptoms during the intake process?					
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?					
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?					
cDC-4	Was the patient scheduled for follow-up treatment as recommended?					
Total Applicable:		10	10	10	10	
Total Met:		10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**	
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes	
2		Y	Yes	Yes	Yes	
3		Y	Yes	Yes	Yes	
4		Y	Yes	Yes	Yes	
5		Y	Yes	Yes	Yes	
6		Y	Yes	Yes	Yes	
7		Y	Yes	Yes	Yes	
8		Y	Yes	Yes	Yes	
9		Y	Yes	Yes	Yes	
10		Y	Yes	Yes	Yes	

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:	3 charts with documentation of time urgency was not included on the off-site service order by the providers						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019		
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			10	10	0	9	
Total Met:			7	10	0	9	
% Compliance:	90%		70%	100%		100%	
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1	(b)(6); (b)(7)(C)	Other	No	Yes	N/A - NLOS	Yes	
2		Orthopedics	Yes	Yes	N/A - NLOS	N/A - LOS	
3		Orthopedics	Yes	Yes	N/A - NLOS	Yes	
4		Gastroenterology	Yes	Yes	N/A - NLOS	Yes	
5		Other	Yes	Yes	N/A - NLOS	Yes	
6		Orthopedics	Yes	Yes	N/A - NLOS	Yes	
7		Gastroenterology	Yes	Yes	N/A - NLOS	Yes	
8		General Surgery	No	Yes	N/A - NLOS	Yes	
9		Infectious Disease	No	Yes	N/A - NLOS	Yes	
10		Infectious Disease	Yes	Yes	N/A - NLOS	Yes	

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	4/5/2019		
		Clinical (c)						
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Rectal Bleeding	Yes	No	Yes	Yes	Yes	
2		Abdominal Pain	Yes	No	Yes	Yes	Yes	
3		Hand Fracture	Yes	No	Yes	Yes	Yes	
4		Abdominal Pain	Yes	No	Yes	Yes	Yes	
5		Abscess	Yes	No	Yes	Yes	Yes	
6		Abdominal Pain	Yes	No	Yes	Yes	Yes	
7		Head Injury	Yes	No	Yes	Yes	Yes	
8		Ankle Injury	Yes	No	Yes	Yes	Yes	
9		Hand Injury	Yes	No	Yes	Yes	Yes	
10		Assualt Injury	Yes	No	Yes	Yes	Yes	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	All Grievances were seen 6-7 days after submittal. 1. Wanting furter care of eye pain 2.Wants stronger pain medication 3. Wants MRI of spine due to continued back pain 4. Awaiting to be called for sick call, seen same day of grivence and day after sick call submittal 5. Wants medication and meals as his prior facility 6. Wants snack lunch 7. Wants dental cleaning prior to 6 months of custody and care for dental braces 8. Wants retreatement for intestinal parasites 9. Wants renewal of vitamins 10. Whats renewal of pain medication						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			10			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			10			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	10	0	1	3	0	0	6
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	Select	1	Select	Select	Select
2		Select	Select	1	Select	Select	Select
3		Select	Select	Select	Select	Select	1
4		Select	Select	1	Select	Select	Select
5		Select	Select	Select	Select	Select	1
6		Select	Select	Select	Select	Select	1
7		Select	1	Select	Select	Select	Select
8		Select	Select	Select	Select	Select	1
9		Select	Select	Select	Select	Select	1
10		Select	Select	Select	Select	Select	1

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	Two detainees identified as having mental health history were not referred to a mental health provider					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	7	6	19
Total Met:		20	20	5	6	19
% Compliance:	94%	100%	100%	71%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A	N/A - NLOS	Yes
4		Yes	Yes	N/A	N/A - NLOS	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	N/A	N/A - NLOS	Yes
8		Yes	Yes	N/A	Yes	N/A - LOS
9		Yes	Yes	N/A	N/A - NLOS	Yes
10		Yes	Yes	No	N/A - NLOS	Yes
11		Yes	Yes	N/A	Yes	Yes
12		Yes	Yes	No	N/A - NLOS	Yes
13		Yes	Yes	N/A	N/A - NLOS	Yes
14		Yes	Yes	N/A	N/A - NLOS	Yes
15		Yes	Yes	N/A	N/A - NLOS	Yes
16		Yes	Yes	N/A	N/A - NLOS	Yes
17		Yes	Yes	N/A	N/A - NLOS	Yes
18		Yes	Yes	Yes	N/A - NLOS	Yes
19		Yes	Yes	Yes	N/A - LOS	Yes
20		Yes	Yes	N/A	N/A - NLOS	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		10	10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019				
Facility (f)									
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y				
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				5				
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0				
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				80				
fMAR-5:	OTCs provided by medical, commissary or both?				Medical				
Clinical (c)									
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?								
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?								
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)								
Total Applicable:			2	2					
Total Met:			2	2					
% Compliance:	100%		100%	100%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	2	N/A - NLOS	N/A - NLOS					
2		1	N/A - NLOS	N/A - NLOS					
3		24	Yes	Yes					
4		0	N/A - NLOS	N/A - NLOS					
5		12	Yes	Yes					
6		2	N/A - NLOS	N/A - NLOS					
7		2	N/A - NLOS	N/A - NLOS					
8		4	N/A - NLOS	N/A - NLOS					
9		2	N/A - NLOS	N/A - NLOS					
10		1	N/A - NLOS	N/A - NLOS					

AMERICAN OVERSIGHT

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 4/5/2019

Facility (f)		
fMR-1:	Type of Medical Records?	Paper
fMR-2:	Name of Electronic Health Record?	Type Text Here

Total Applicable:		10	10	10	10	10	10	6	10	10	10	5	1	8	10	10	10	10	0	10	0	0
Total Met:		10	10	10	10	10	10	6	10	10	10	5	1	8	10	10	10	10	0	10	0	0
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	5. Hx of depression and cutting viens, no MH referral 6. Hx of anxiety with medication treatment, no MH referral								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	4/5/2019					
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		8							
% Compliance:	80%	80%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		No							
6		No							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	5						
Total Met:		10	5						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	N/A - LOS						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	N/A - LOS						
8		Yes	N/A - LOS						
9		Yes	N/A - LOS						
10		Yes	N/A - LOS						

AMERICAN OVERSIGHT

PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	Females are not detained at the faciilty at this time						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			N/A			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	Note: The review of the security officer's suicide watch form by medical staff is not being documented					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	4/5/2019		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		17			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Total Applicable:			10	10	10	10
Total Met:			10	10	10	10
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		Constant (1:1)	Yes	Yes	Yes	No
10		Constant (1:1)	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		7				
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	The prominent identification on medical record for detainees with disabilities is not completed Detainees with disabilities do not have documentation of being assessed for needed assistance with ADLs (Activities of Daily Living).					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	4/5/2019	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Total Applicable:		7	7	7	0	
Total Met:		4	4	7	0	
% Compliance:	71%	57%	57%	100%		
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	No	Yes	N/A - NLOS	
2		Yes	Yes	Yes	N/A - NLOS	
3		No	Yes	Yes	N/A - NLOS	
4		Yes	Yes	Yes	N/A - NLOS	
5		No	No	Yes	N/A - NLOS	
6		Yes	No	Yes	N/A - NLOS	
7		No	Yes	Yes	N/A - NLOS	
8		Select	Select	Select	Select	
9		Select	Select	Select	Select	
10		Select	Select	Select	Select	

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	Type Text Here							
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**		4/5/2019	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	6	6	
Total Met:			10	10	10	6	6	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Epigastric Pain	Yes	Yes	Yes	Yes	Yes	
2		Claiming Suicidal	Yes	Yes	Yes	Yes	Yes	
3		Abdominal Pain	Yes	Yes	Yes	Yes	Yes	
4		Constipation/Abd Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
5		Ear Pain	Yes	Yes	Yes	Yes	Yes	
6		Throat Pain	Yes	Yes	Yes	Yes	Yes	
7		Abdominal Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
8		Constipation	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
9		Respiratory Infection	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
10		Ingrown Toe Nail	Yes	Yes	Yes	Yes	Yes	

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
01/08/2018	08/21/2017	Otero County Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
667	667	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
1	1	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (575) 827- (b)(6); (b)(7)(C)	Phone Number: +1 (915) 575- (b)(6); (b)(7)(C)
Address: 26 McGregor Range Road Chaparral, New Mexico 88081	Address: 26 McGregor Range Road Chaparral, New Mexico 88081

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were no identified medical care standards deficiencies.

Prior site visit finding form August 2017:
There were no identified medical care standards deficiencies.

Chronic Care

Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.

Total number with chronic conditions:	Total number with unstable chronic conditions:
98	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. For those detainees with chronic conditions who remain for 90 days or greater, their special diets are reviewed and renewed every 90 days. The facility uses BOP guidelines for chronic illnesses.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 2 hunger strike medical records noted to comply with NCCHC and PBNDS standards. Review of medical staff training records had required hunger strike education documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	14

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 suicide watch medical records noted to comply with NCCHC and PBNDS standards. All were placed on 1:1 constant watch, and every 15 minute documentation of patient observation was noted in the medial charts. Review of medical staff training records had required suicide prevention and intervention documentation.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS and NCCHC standards.

Other Observations

Site Visit from 1/8/2018 to 1/11/2018. A total of 106 medical records were reviewed during this site visit.

Facility Data:

IGSA operated by Management and Training Corporaton (MTC), including medical.
Maximum ICE population 1089, current population 667, all male facility, to include all three levels of ICE detainees.
Designated ICE/ERO Interior Repatriation Initiative (IRI) facility with most detainees staying less than 2 weeks.

NCCHC Certification - December 2015
ACA Certification - November 2015
PBNDS (Nakamoto Group) Feb 2017- No medical deficiencies found.

Type of Medical Records: Paper charts, no current plan for Electronic Medical Record.

The Medical Housing Unit has 15 beds. Seven medical/negative pressure rooms, seven medical observation rooms, and one suicide prevention room.

Current Staffing:

(b)(7)(E)

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Type of Medical Records: Paper charts, no current plan for Electronic Medical Record.

The Medical Housing Unit has 15 beds. Seven medical/negative pressure rooms, seven medical observation rooms, and one suicide prevention room.

--(b)(7)(E) Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.
--Review of all medical staff training records found to have the mandatory training and job specific training documents up-to-date.
--Man-Down drills documented and completed by medical staff once a month.
--Sick call observed, process and procedure reviewed; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Quarterly review by pharmacy noted; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Lab area refrigerator temperature log verified and accurate.
--Non-prescription commissary list reviewed annually by medical and facility administrators.
--Transfers and intakes usually occur in the evening/night.
--Consents and refusals were noted accurately in charts reviewed.
--Medical diets are available and ordered. The diets are renewed as needed.
--Noted lab results are being acknowledged by the ordering provider and reviewed with the detainees.
--Transgender housing and care is based on the PBNDS 2011 standards; no issues were identified.
--Chronic care patients are not being evaluated in a chronic care visit by a provider within 14 days of identification.

Deficiencies for Areas Evaluated

PBNDS 2011:
There were no identified medical care standards deficiencies.

Quality of Care:
--Chronic care patients are not being evaluated in a chronic care visit by a provider within 14 days of identification.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

10 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

-There have been 14 suicide watches the since last site visit.
-The facility mental health professional uses a suicide risk management screening instrument that does include the asking for a history of suicide attempts and for current suicidal ideation.
-All medical staff in direct contact with detainees are trained to assess suicide risk.

Ten of ten (100%) were evaluated by a mental heal professional within 24 hours of identification, and daily while on suicide watch.
Ten of ten (100%) were on constant 1:1 watch by a security officer with checks documented consistently.
Ten of ten (100%) had no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

Health Assessment

20 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Twenty of twenty (100%) had initial screenings that were completed within 12 hours of arrival.
Twenty of twenty (100%) had PPD placed during medical screen when applicable and read within 48-72. If not having a completed TB screening chest x-ray prior to arriving to facility, per facility policy, a chest x-ray was completed on site.
Two of two (100%) of charts with positive screening for mental illness or suicide risk were referred for evaluation. The other eighteen charts has negative screenings.
Twelve of twelve (100%) had timely follow up of a chronic condition. The other 8 charts had no chronic conditions.
Twenty of twenty (100%) had completed health assessments within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days.

Urgent Care (Sick Call)

10 charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and documented vital signs.
Three of three (100%) had referrals to MD/MLP/DMD within 24 hours where appropriate.
Three of three (100%) that had been referred, had MD/MLP/DMD documented assessment and plan.

Sick call requests were collected and triaged daily if indicated. Non-urgent requests were evaluated the following day. The urgent care room had appropriate supplies and equipment needed for urgent/emergent care within the capabilities stated in facility policy (BLS).

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

10 charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had notes for each outbound emergency encounter and had no evidence that earlier intervention may have prevented the need for ED referral or admission.
Ten of ten (100%) had discharge documentation from the hospital/Emergency Department(ED), and an inbound assessments with no deviations from hospital/ED recommendations upon return to the facility.

Medication Administration Practices

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

No charts reviewed needed to be referred to a provider for 3 or more refusals.

The facility currently uses electronic MARs which showed no missed doses other than for

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refusals, which were verified as having been documented in the patient medical charts. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

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Continuity of Medication

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had medication ordered in less than 24 hours from time of completed intake screening.
Ten of ten (100%) had the first dose of medication administered in less than 24 hours.

Mental Health Screen

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of Ten (100%) that had a positive screen for mental illness or suicide risk were referred for evaluation and were evaluated by the LPC in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days).

Medical Recordkeeping Practices

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

The facility uses paper charting and currently has no plans for a electronic health record. Facility medical records were found to be complaint in identifying information, current problem list, receiving screen and health assessment forms, encounters with significant findings/ diagnosis/treatments/and dispositions, signed clinician orders for medications, placement of Medication Administration Records within 2 weeks of previous month, acknowledgment and dating of lab and diagnostic reports, flowsheets, consents for medical care and treatment, signing of refusals of care, documented date and time on each encounter, integrating medical/dental/mental health records, and timely filing within 72 hours.

Pregnant Women

Females are not detained at this facility at this time.

Dental Care

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) were screened for dental symptoms during the intake process.
Ten of ten (100%) were evaluated by a qualified health professional within 48 hours of request, and dental clinical notes described findings, diagnosis, treatment and plan.
Ten of ten (100%) that required follow-up treatment were scheduled for an appointment.

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Acute Laboratory Testing

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had blood drawn or test done within 1 business day of the ordered date. One detainee was transfered/removed prior to blood being drawn.
Ten of ten (100%) with non acute routine lab orders had a report of results within 7 days, clinical acknowledgment, and an appropriate clinical response.
Nine of nine (100%) had documentation that the lab results were reviewed with the detainee. One detainee chart was not-applicable due to being transfered/removed prior to follow up appointment to review laboratory results.

Diagnostic Services and Specialty Care Access

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a documented time of urgency included on the order for specialty care or diagnostic services.
Ten of ten (100%) had the appointment accomplished within 45 days of the order or within the ordered time-frame, e.g. "return in 90 days."
Zero of Zero (100%) needed re-evaluation for deterioration every 30 days until off-site since all had their appointments completed withing 30 days.
Ten of ten (100%) specialist reports had documentation of acknowledgment by the facility clinician within 7 days of the date the service was performed.

Mental Health Treatment Planning

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a clinical assessment, treatment, and follow-up plan documented.
Ten of ten (100%) had a treatment plan updated at a minimum of every 90 days.

El Paso Behavioral Health Hospital is used as needed for inpatient psychiatric services.

Treatment of Disability

No charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

There were no identified detainees with disabilities since the last site visit. Review of facility disabilities policy noted to follow NCCHC and PBNDS standards.

Complaints and Grievances

No charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

There have been no medical grievances in the last three months.

Review of the grievance process did not reveal any possible barriers to care or repetitive concerns that could affect clinical care.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had blood sugar measured and recorded on intake.
Nine of nine (100%) were seen for chronic care by MLP/MD within 14 days of illness identification. One patient was transfered/removed prior to the scheduled appointment.
Six of six (100%) had HgbA1c performance within 30 days; the other four were deported/ released prior to 30 days.
Three of three (100%) had lipids measured within one year. The other 7 had either not been at the facility for one year or were deported/released prior to one year.
Five of five (100%) had been followed at least every 90 days with appropriate vital signs. The other 5 patients were transfered/removed prior to the scheduled appointment.
None had any clinical indications for aspirin.
Four of four (100%) had the degree of diabetes control or a strategy to attain diabetes control when HbBA1C was above goal. Six were not-applicable due being transfered/removed prior to follow up appointment or prior to blood draw.

Human Immunodeficiency Virus (HIV)

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had HIV status identified by prior medical records and had antiretroviral treatment considered and documented.
Eight of eight (100%) had CD4+ and viral load completed within 14 days of arrival or within the last 3 months. One was not-applicable due to being transfered/removed prior to having blood drawn, and another refused the laboratory testing.
Four of four (100%) were seen by an HIV or ID specialist within 30 days of HIV identification. Six were not-applicable due to being transfered/removed prior to 30 days.
Ten of ten (100%) were seen by a mid-level provider or physician for chronic care at least every 90 days.
Ten of ten (100%) had a chest x-ray completed within 72 hours of problem identification, if not already done.

Hypertension

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had documented blood pressure reading at intake
Nine of nine (100%) were seen by an MD/PA/ NP within 14 days of illness identification. One was non-applicable due to being transfered/removed prior to the scheduled appointment.
Two of two (100%) whose blood pressure was >140 systolic or >90 diastolic had a treatment plan initiated within 14 days of identification.
Ten of ten (100%) had chronic disease guideline usage with included baseline laboratory.

Asthma

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Three of four (75%) were see by a provider within 14 days of illness identification.
Ten of ten (100%) had peak flow completed on initial physical exam.
Three of three (100%) had peak flow completed at the Chronic Care visit. The other six were transfered/removed prior to the scheduled appointment.
Ten of ten (100%) followed chronic disease guidelines, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

Seizure Disorder

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had an appropriate neurological history completed at the initial physical

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examination.
One of three (33%) were seen by a provider within 14 days of illness identification.
Five of five (100%) had serum drug levels performed and acknowledged in the medical record at least every 3 months until stable. Five were either transfered/removed prior to blood being drawn or arrived to the facility with recent documented drug levels.
Ten of ten (100%) had a treatment plan established.
Ten of ten (100%) had orders for a bottom bunk.

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Recommendations

(b)(5)

Facility Actions

HSA and Director of Nursing had a short meeting with FMC to discuss issues identified. Per HSA statements:
--Staff will be educated on scheduling initial chronic care visits within 14 days of chronic illness identification.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 01/30/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 369-(b)(6); (b)(7)(C)	Date Reviewed: 07/26/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/26/2018

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
04/05/2019	08/16/2018	Otero County Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,035	1,035	0	2	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
10	5	5	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (575) 827- (b)(6); (b)(7)(C)	Phone Number: +1 (915) 575- (b)(6); (b)(7)(C)
Address: 26 McGregor Range Road Chaparral, New Mexico 88081	Address: 26 McGregor Range Road Chaparral, New Mexico 88081

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were no identified medical care standard deficiencies.

Prior site visit finding form August 2018:
There were no identified medical care standards deficiencies.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
99	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. For those detainees with chronic conditions who remain for 90 days or greater, their special diets are reviewed and renewed every 90 days. The facility uses BOP guidelines for chronic illnesses.
Quality of Care Finding: Detainees with identified chronic conditions are not timely evaluated by a medical provider.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	43

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 hunger strike medical records noted to comply with NCCHC and PBNDS standards.

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Review of medical staff training records had required hunger strike education documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	40

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 suicide watch medical records noted to comply with NCCHC and PBNDS standards. All were placed on 1:1 constant watch, and every 15 minute documentation of patient observation was noted in the medical charts. Review of medical staff training records had required suicide prevention and intervention training documented.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS and NCCHC standards.

Other Observations

Site Visit from 4/5/2019 to 4/8/2019. A total of 112 medical records were reviewed during this site visit.

Facility Data:

IGSA operated by Management and Training Corporaton (MTC), including medical.
Maximum ICE population 1089, current population 1035, all male facility, to include all three levels of ICE detainees. Most detainees stay less than 2 weeks.

NCCHC Certification - February 2019 - No deficiencies found.
ACA Certification - November 2018 - No medical deficiencies found.
PBNDS (Nakamoto Group) Feb 2018- No medical deficiencies found.

Type of Medical Records: Paper charts, no current plan for Electronic Medical Record.

The Medical Housing Unit has 15 beds. Seven medical/negative pressure rooms, seven medical observation rooms, and one suicide prevention room.

Current Staffing:

(b)(7)(E)

--Reviewed (b)(7)(E) Licensed personnel had current copies of

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licensing, and the staff had up-to-date BLS certification.
--Review of all medical staff training records found to have the mandatory training and job specific training documents up-to-date.
--Man-Down drills documented and completed by medical staff once a month.
--Sick call observed, process and procedure reviewed; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Quarterly review by pharmacy noted; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Lab area refrigerator temperature log verified and accurate.
--Non-prescription commissary list reviewed annually by medical and facility administrators.
--Transfers and intakes usually occur in the evening/night.
--Medical diets are available and ordered. The diets are renewed as needed.
--Noted lab results are being acknowledged by the ordering provider and reviewed with the detainees.

Deficiencies for Areas Evaluated

PBNDS 2011:
There were no identified medical care standards deficiencies.

Quality of Care:
--Transgender detainees are not considered chronic medical cases by the facility and are not referred to a medical provider for chronic care
--Detainees with chronic medical conditions are not seen within 14 days by a medical provider for chronic care
--Medical intake detainees identified as having a mental health history are not being referred to a mental health provider.
--The prominent identification on medical record for detainees with disabilities is not completed
--Detainees with disabilities do not have documentation of being assessed for needed assistance with ADLs (Activities of Daily Living).
--Detainees arriving with prescribed medications are not having their medications continued
--Time urgency is not documented by providers on referrals to outside specialties
--The review of the security officer's suicide watch form by medical staff is not documented

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to QMC Tool.

Health Assessment

Refer to QMC Tool.

Urgent Care (Sick Call)

Refer to QMC Tool.

Sick call requests were collected and triaged daily. Non-urgent requests were evaluated the following day. The urgent care room had appropriate supplies and equipment needed for urgent/ emergent care within the capabilities stated in facility policy (BLS).

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to QMC Tool.

Medication Administration Practices

Refer to QMC Tool.

The facility currently uses electronic MARs which showed no missed doses other than for refusals, which were verified as having been documented in the patient medical charts. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

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Continuity of Medication

Refer to QMC Tool.

Mental Health Screen

Refer to QMC Tool.

Medical Recordkeeping Practices

Refer to QMC Tool.

Pregnant Women

Females are not detained at the facility at this time.

Dental Care

Refer to QMC Tool.

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Acute Laboratory Testing

Refer to QMC Tool.

Diagnostic Services and Specialty Care Access

Refer to QMC Tool.

Mental Health Treatment Planning

Refer to QMC Tool.

El Paso Behavioral Health Hospital is used as needed for inpatient psychiatric services.

Treatment of Disability

Refer to QMC Tool.

Complaints and Grievances

Refer to QMC Tool.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to QMC Tool.

Human Immunodeficiency Virus (HIV)

Refer to QMC Tool.

Hypertension

Refer to QMC Tool.

Asthma

Refer to QMC Tool.

Seizure Disorder

Refer to QMC Tool.

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Recommendations

(b)(5)

Facility Actions

HSA, DON, and facility ICE personnel had a short meeting with FMC to discuss the facility findings.

Per HSA Statement:

Facility CQI program will continue along with the use of IHSC site visit tools. The quality of care issues will be addressed.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 04/11/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 04/23/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 04/25/2019

Recommendations:

(b)(5)

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Reset Form | Email Form | Print Form

DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
08/16/2018	01/08/2018	Otero County Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
941	941	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
3	1	2	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (575) 827- (b)(6); (b)(7)(C)	Phone Number: +1 (915) 575- (b)(6); (b)(7)(C)
Address: 26 McGregor Range Road Chaparral, New Mexico 88081	Address: 26 McGregor Range Road Chaparral, New Mexico 88081

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were no identified medical care standards deficiencies.

Prior site visit finding form January 2018:
There were no identified medical care standards deficiencies.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
103	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. For those detainees with chronic conditions who remain for 90 days or greater, their special diets are reviewed and renewed every 90 days. The facility uses BOP guidelines for chronic illnesses.
Quality of Care Finding: Detainees with identified chronic conditions are not timely evaluated by a medical provider.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
1	22

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 hunger strike medical records noted to comply with NCCHC and PBNDS standards.

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Review of medical staff training records had required hunger strike education documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	27

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 suicide watch medical records noted to comply with NCCHC and PBNDS standards. All were placed on 1:1 constant watch, and every 15 minute documentation of patient observation was noted in the medical charts. Review of medical staff training records had required suicide prevention and intervention training documented.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS and NCCHC standards.

Other Observations

Site Visit from 8/16/2018 to 8/18/2018. A total of 97 medical records were reviewed during this site visit.

Facility Data:

IGSA operated by Management and Training Corporaton (MTC), including medical.
Maximum ICE population 1089, current population 941, all male facility, to include all three levels of ICE detainees. Most detainees stay less than 2 weeks.

NCCHC Certification - December 2015
ACA Certification - November 2015
PBNDS (Nakamoto Group) Feb 2018- No medical deficiencies found.

Type of Medical Records: Paper charts, no current plan for Electronic Medical Record.

The Medical Housing Unit has 15 beds. Seven medical/negative pressure rooms, seven medical observation rooms, and one suicide prevention room.

Current Staffing:

(b)(7)(E)

(b)(7)(E) Licensed personnel had current copies of

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licensing, and the staff had up-to-date BLS certification.
--Review of all medical staff training records found to have the mandatory training and job specific training documents up-to-date.
--Man-Down drills documented and completed by medical staff once a month.
--Sick call observed, process and procedure reviewed; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Quarterly review by pharmacy noted; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Lab area refrigerator temperature log verified and accurate.
--Non-prescription commissary list reviewed annually by medical and facility administrators.
--Transfers and intakes usually occur in the evening/night.
--Medical diets are available and ordered. The diets are renewed as needed.
--Noted lab results are being acknowledged by the ordering provider and reviewed with the detainees.
--Transgender housing and care is based on the PBNDS 2011 standards; no issues were identified.

Deficiencies for Areas Evaluated

PBNDS 2011:
There were no identified medical care standards deficiencies.

Quality of Care:
--Chronic care patients are not being evaluated in a chronic care visit by a provider within 14 days of identification.
--Detainees with HIV are not evaluated by a infectious disease specialist within 30 days of arrival.
--Detainees with HIV are not getting a CXR completed within 72 hours of problem identification.
--Asthma patients are not having their inhalers continued within 24 hours of arrival.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to QMC Tool.

Health Assessment

Refer to QMC Tool.

Urgent Care (Sick Call)

Refer to QMC Tool.

Sick call requests were collected and triaged daily. Non-urgent requests were evaluated the following day. The urgent care room had appropriate supplies and equipment needed for urgent/ emergent care within the capabilities stated in facility policy (BLS).

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to QMC Tool.

Medication Administration Practices

Refer to QMC Tool.

The facility currently uses electronic MARs which showed no missed doses other than for refusals, which were verified as having been documented in the patient medical charts. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

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Continuity of Medication

Refer to QMC Tool.

Mental Health Screen

Refer to QMC Tool.

Medical Recordkeeping Practices

Refer to QMC Tool.

Pregnant Women

Females are not detained at the facility at this time.

Dental Care

Refer to QMC Tool.

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Acute Laboratory Testing

Refer to QMC Tool.

Diagnostic Services and Specialty Care Access

Refer to QMC Tool.

Mental Health Treatment Planning

Refer to QMC Tool.

El Paso Behavioral Health Hospital is used as needed for inpatient psychiatric services.

Treatment of Disability

No charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

There were no identified detainees with disabilities since the last site visit. Review of facility disabilities policy noted to follow NCCHC and PBNDS standards.

Complaints and Grievances

Refer to QMC Tool.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to QMC Tool.

Note: QMC Tool c-DM-2 correct percentage is 50% and not 70%.

Human Immunodeficiency Virus (HIV)

Refer to QMC Tool.

Note: QMC Tool c-HIV-3 correct percentage is 0% and not 80%.

Hypertension

Refer to QMC Tool.

Six of nine (67%) were seen by an MD/PA/ NP within 14 days of illness identification. One was non-applicable due to being transfered/removed prior to the scheduled appointment. Note: QMC Tool cHTN-2 correct percentage is 67% and not 70%
Seven of seven (100%) whose blood pressure was >140 systolic or >90 diastolic had a treatment plan initiated within 14 days of identification.
Nine of nine (100%) had chronic disease guideline usage with included baseline laboratory. One was non-applicable due to being removed/transfered within 3 days of arrival

Asthma

Refer to QMC Tool.

Three of nine (57%) were see by a provider within 14 days of illness identification. One was non-applicable due to being transferred/removed prior to 14 days. Note: QMC Tool cASM-1 correct percentage is 57% and not 40%
Eight of eight (100%) had peak flow completed at the chronic care visit. The other six were transfered/removed prior to the scheduled appointment. Two were non-applicable due to being transferred/removed prior to their scheduled chronic care visit.

Seizure Disorder

Refer to QMC Tool.

Four of seven (57%) were seen by a provider within 14 days of illness identification. Three were non-applicable due to being transferred/removed prior to 14 days. Note: QMC Tool cSZ-2 correct percentage is 57% and not 70%
Four of four (100%) had serum drug levels performed and acknowledged in the medical record at least every 3 months until stable. Five were either transfered/removed prior to blood being drawn or arrived to the facility with recent documented drug levels. One was not on seizure medication.

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Recommendations

(b)(5)

Facility Actions

HSA, warden, and facility ICE personnel had a short meeting with FMC to discuss the facility findings.

Per HSA Statement:

Facility CQI program will continue along with the use of IHSC site visit tools. The quality of care issues will be addressed.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 02/14/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 02/22/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 03/07/2019

Recommendations:

(b)(5)

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Otero County Processing Center			
AOR:*	ELP			
Address:	26 McGregor Range Road			
City:	Chaparral		**County:**	Dona Ana
State:*	TX	**Zip:**		
Inspection Information				
Start Date:*	8/16/2018			
End Date:*	8/18/2018			
Organization:*		IHSC		
# Detainees at Time of Visit:		941		
Total Facility Population at Time of Visit:		941		
Facility Capacity:		1089		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	2/14/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	85%	
CG	Complaints and Grievance	7	*Total Number
CM	Continuity of Medications	95%	
DC	Dental Care	100%	
DM	Diabetes	96%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	80%	
HA	Health Assessment	95%	
HIV	Human Immunodeficiency Virus	94%	
HTN	Hypertension	93%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder	94%	
SS	Suicide Screening	100%	
TD	Treatment of Disability		
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1 (Admin Clerk)						
Other 2 (Rad Tech/Clerk)						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs (Medical Administrative Record).					
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm					
Remarks:	Note cASM-1 correct percentage is 57% and not 40%					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	
Facility (f)						
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y	
fASM-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cASM-2	Was a peak flow completed at the initial physical exam?					
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?					
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.					

Totals:	10	4	10	10	10
Compliance:	85%	40%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes
2		No	Yes	Yes	Yes
3		No	Yes	Yes	Yes
4		No	Yes	Yes	Yes
5		Yes	Yes	N/A - LOS	Yes
6		No	Yes	Yes	Yes
7		No	Yes	Yes	Yes
8		N/A - LOS	Yes	N/A - LOS	Yes
9		No	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Note: QMC Tool c-DM-2 correct percentage is 50% and not 70%.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 8/16/2018

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP

Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Totals:	10	10	7	10	10	10	10	10	10
Compliance:	96%	100%	70%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	Yes
2		Yes	No	Yes	Yes	N/A - LOS	Yes	Yes	Yes
3		Yes	No	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - NLOS	N/A - LOS	N/A - LOS
4		Yes	No	N/A - LOS	N/A - LOS	N/A - LOS	Yes	N/A - LOS	N/A - LOS
5		Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	Yes	N/A - LOS	N/A - LOS
6		Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
7	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	
8		Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	Yes	N/A - LOS	N/A - LOS	
9		Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A - LOS	
10		Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	Yes	N/A - LOS	N/A - LOS	

AMERICAN OVERSIGHT

HIV								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu					
	University of California, San Francisco. HIV Clinical Consultation Center.							
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
Remarks:	Note: QMC Tool c-HIV-3 correct percentage is 0% and not 80%.							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	8/16/2018				
Facility (f)								
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	Type Text Here						
Clinical (c)								
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?							
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
cHIV-4	Was antiretroviral treatment considered and documented?							
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
Totals:	10		10	8	10	10	9	
Compliance:	94%		100%	80%	100%	100%	90%	
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
1	(b)(6); (b)(7)(C)	Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	No	

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
2	(b)(6); (b)(7)(C)	Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	
3		Medical Record	Yes	No	Yes	Yes	Yes	
4		Medical Record	Yes	No	Yes	Yes	Yes	
5		Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
6		Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	
7		Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	
8		Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	
9		Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
10		Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	

AMERICAN OVERSIGHT

HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:	Note: QMC Tool cHTN-2 correct percentage is 67% and not 70%					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					

Totals:	10	10	7	10	10
Compliance:	93%	100%	70%	100%	100%

Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes
2		Y	No	Yes	Yes
3		Y	No	N/A - NLOS	Yes
4		Y	Yes	Yes	Yes
5		Y	No	Yes	Yes
6		Y	Yes	Yes	N/A - LOS
7		Y	Yes	Yes	Yes
8		Y	N/A - LOS	Yes	Yes
9		Y	Yes	N/A - NLOS	Yes
10		Y	Yes	N/A - NLOS	Yes

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~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	Note: QMC Tool cSZ-2 correct percentage is 57% and not 70%					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					

Totals:	10	10	7	10	10	10
Compliance:	94%	100%	70%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	No	N/A - NLOS	Yes	Yes
2		Yes	Yes	N/A - NLOS	Yes	Yes
3		Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	No	Yes	Yes	Yes
5		Yes	Yes	N/A - LOS	Yes	Yes
6		Yes	N/A - LOS	N/A - LOS	Yes	Yes
7		Yes	N/A - LOS	Yes	Yes	Yes
8		Yes	N/A - LOS	N/A - LOS	Yes	Yes
9		Yes	No	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess timeliness of medication, as ordered.							
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).							
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.							
Guidelines:								
Remarks:	1) Inhaler not coninued on intake							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018			
Clinical (c)								
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?							
cCM-2	Period of time from order to first dose less than 24 hours?							
Totals:	10	9	10					
Compliance:	95%	90%	100%					
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**					
1	(b)(6); (b)(7)(C)	No	N/A - NLOS					
2		Yes	Yes					
3		Yes	Yes					
4		Yes	Yes					
5		Yes	Yes					
6		Yes	Yes					
7		Yes	Yes					
8		Yes	Yes					
9		Yes	Yes					
10		Yes	Yes					

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Totals:	10	10	10	10	10			
Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	N/A - NLOS			
3		Y	Yes	Yes	N/A - NLOS			
4		Y	Yes	Yes	N/A - NLOS			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	

Clinical (c)						
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?					
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?					
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?					
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?					
Totals:	10		10	10	10	10
Compliance:	100%		100%	100%	100%	100%

Patient(s)	A# (numbers only)	Clinic	cDSA-1	cDSA-2	cDSA-3	cDSA-4
1	(b)(6); (b)(7)(C)	Orthopedics	Yes	Yes	N/A - NLOS	Yes
2		Opthalmology	Yes	Yes	N/A - NLOS	Yes
3		Other	Yes	Yes	N/A - NLOS	Yes
4		Gastroenterology	Yes	Yes	N/A - NLOS	Yes
5		Infectious Disease	Yes	Yes	N/A - NLOS	Yes
6		Other	Yes	Yes	N/A - NLOS	Yes
7		Other	Yes	Yes	N/A - NLOS	Yes
8		Gastroenterology	Yes	Yes	N/A - NLOS	Yes
9		Other	Yes	Yes	N/A - NLOS	Yes
10		Opthalmology	Yes	Yes	N/A - NLOS	Yes

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.		
Source:	Emergency Department (ED) logs.		
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.		
Guidelines:	NCCHC 2014 J-E-12.		
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	8/16/2018

	Clinical (c)
cEED-1	Is there an outbound progress note?
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.
cEED-3	Is there discharge documentation from the hospital or ED in the chart?
cEED-4	Is there an inbound assessment?
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?

Totals:	10		10	0	10	10	10
Compliance:	80%		100%	0%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
1	(b)(6); (b)(7)(C)	Gluetial Abscess	Yes	No	Yes	Yes	Yes
2		Appendicitis	Yes	No	Yes	Yes	Yes
3		Seizure	Yes	No	Yes	Yes	Yes
4		Head truama	Yes	No	Yes	Yes	Yes
5		Abdominal pain	Yes	No	Yes	Yes	Yes
6		Abdomminal pain	Yes	No	Yes	Yes	Yes
7		Chest pain	Yes	No	Yes	Yes	Yes
8		hypetesion, abnormal EGK	Yes	No	Yes	Yes	Yes
9		Sickle cell crisis	Yes	No	Yes	Yes	Yes
10		Chest pain	Yes	No	Yes	Yes	Yes

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	7						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			7			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			7			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	7	0	2	3	0	2	0
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	1	Select	Select	Select	Select
2		Select	1	Select	Select	Select	Select
3		Select	Select	1	Select	Select	Select
4		Select	Select	1	Select	Select	Select
5		Select	Select	1	Select	Select	Select
6		Select	Select	Select	Select	1	Select
7		Select	Select	Select	Select	1	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Totals:	20	20	20	20	20	15
Compliance:	95%	100%	100%	100%	100%	75%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	N/A	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	N/A	Yes	No
11		Yes	Yes	N/A	N/A - LOS	Yes
12		Yes	Yes	N/A	Yes	No
13		Yes	Yes	N/A	Yes	No
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	N/A	Yes	No
16		Yes	Yes	N/A	Yes	No
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	N/A	Yes	Yes
20		Yes	Yes	N/A	N/A - NLOS	Yes

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LABORATORY TESTING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess timeliness, continuity, and coordination of care.					
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.					
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.					
Guidelines:						
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018	
Clinical (c)						
cLT-1	Was blood drawn or test done within 1 business day of ordered date?					
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?					
cLT-3	Was there clinical acknowledgment?					
cLT-4	Was there an appropriate clinical response?					
cLT-5	Was patient advised of laboratory results?					
Totals:	10	10	10	10	10	10
Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	N/A - LOS
10		Yes	Yes	Yes	Yes	Yes

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:	None of the charts reviewed needed to be referred to a provider for 3 or more refusals.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018				
Facility (f)									
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y				
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				5				
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0				
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				80				
fMAR-5:	OTCs provided by medical, commissary or both?				Medical				
Clinical (c)									
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?								
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?								
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)								
Totals:	10	16	10	10					
Compliance:	100%		100%	100%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS					
2		0	N/A - NLOS	N/A - NLOS					
3		0	N/A - NLOS	N/A - NLOS					
4		0	N/A - NLOS	N/A - NLOS					
5		0	N/A - NLOS	N/A - NLOS					
6		4	N/A - NLOS	N/A - NLOS					
7		4	N/A - NLOS	N/A - NLOS					
8		7	N/A - NLOS	N/A - NLOS					
9		0	N/A - NLOS	N/A - NLOS					
10		1	N/A - NLOS	N/A - NLOS					

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MEDICAL RECORD-KEEPING PRACTICES																							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select # files/patients reviewed)	10																						
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.																						
Source:	Medical Records, Chronic Care Log, and MARs.																						
Sample:	10 records of detainees with chronic disease, if available.																						
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."																						
Guidelines:	NCCHC 2014 J-H-01, J-H-03.																						
Remarks:																							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018																		
Facility (f)																							
fMR-1:	Type of Medical Records?		Paper																				
fMR-2:	Name of Electronic Health Record?		N/A																				
Totals:	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	8/16/2018				
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Totals:	10	10						
Compliance:	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		Yes						
3		Yes						
4		Yes						
5		Yes						
6		Yes						
7		Yes						
8		Yes						
9		Yes						
10		Yes						

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).		
Source:	Patients on mental health caseload, including all patients on psychotropic medication.		
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.		
Guidelines:	NCCHC 2014 J-G-04 (Item 2)		
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	8/16/2018

Clinical (c)			
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?		
cMHT-2	Are treatment plans updated at a minimum of every 90 days?		
Totals:	10	10	10
Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cMHT-1	cMHT-2					
1	(b)(6); (b)(7)(C)	Yes	N/A - LOS					
2		Yes	N/A - LOS					
3		Yes	N/A - LOS					
4		Yes	N/A - LOS					
5		Yes	N/A - LOS					
6		Yes	N/A - NLOS					
7		Yes	N/A - LOS					
8		Yes	N/A - LOS					
9		Yes	N/A - LOS					
10		Yes	N/A - LOS					

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0						
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	Females are not currently detainee at OCPC						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Select			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Totals:	0	0	0	0	0	0	
Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	8/16/2018		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		5			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Totals:	10		10	10	10	10
Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		Constant (1:1)	Yes	Yes	Yes	No
10		Constant (1:1)	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0						
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	No Identifed Detainees with disabilities since last site visit						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	8/16/2018		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Totals:	0	0	0	0	0		
Compliance:							
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1		Select	Select	Select	Select		
2		Select	Select	Select	Select		
3		Select	Select	Select	Select		
4		Select	Select	Select	Select		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	8/16/2018	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Totals:	10		10	10	10	10	10	
Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Tail bone pain	Yes	Yes	Yes	Yes	Yes	
2		Hand pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
3		congestion	Yes	Yes	Yes	Yes	Yes	
4		Fell from top bunk, knee pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
5		requested to se MH	Yes	N/A - NLOS	N/A - NLOS	Yes	Yes	
6		Heartburn	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
7		Hernia pain	Yes	Yes	Yes	Yes	Yes	
8		Constipation, bloody stool	Yes	Yes	Yes	Yes	Yes	
9		nightmares and symptoms	Yes	Yes	Yes	Yes	Yes	
10		Lump in throat	Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? BOP

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		NO	YES	NA	YES
3		YES	YES	YES	YES
4		NA	YES	NA	YES
5		YES	YES	YES	YES
6		NA	YES	NA	YES
7		NA	YES	NA	YES
8		NA	YES	NA	YES
9		NA	YES	NA	YES
10		NA	YES	NA	YES
	Total	3 / 4 75 %	10 / 10 100 %	3 / 3 100 %	10 / 10 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 01/09/42018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? BOP

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	NO	YES	YES	YES
2		YES	NA	YES	YES	YES
3		YES	NA	NA	YES	YES
4		YES	NA	NA	YES	YES
5		YES	NA	NA	YES	YES
6		YES	NA	NA	YES	YES
7		YES	NA	NA	YES	YES
8		YES	NA	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	NO	YES	YES	YES
	Total	10 / 10 100 %	1 / 3 33.3%	5 / 5 100 %	10 /10 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

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DHS-ICE-20-0618-A-001820

COMPLAINTS AND GRIEVANCES

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no no If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 0

What percentage of this number were appropriately addressed within 5 working days of receipt? n/a %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	0	
Denial or refusal of specific request(s) for care	0	
Delay(s) in care	0	
Competency/professional skillset of medical staff	0	
Attitude, demeanor or conduct of staff	0	
Other	0	
Total	0	

NCCHC 2014 J-A-06, J-A-11.

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CONTINUITY OF MEDICATION

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed February 2017

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DHS-ICE-20-0618-A-001822

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
06/24/2019	03/20/2018	Rio Grande Detention Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	SNA AOR

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
734	734	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	1	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (956) 718 (b)(6); (b)(7)(C)	Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)
Address: 1001 San Rio Blvd. Laredo, TX 78046	Address: 1001 San Rio Blvd. Laredo, TX 78046

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 2008 DEFICIENCIES:
No findings noted.

PREVIOUS FINDINGS (MARCH 2018):

No findings noted.

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
32	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during March 2018 site visit.

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is compliant with PBNDS 2008.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during March 2018 site visit. No declared hunger strikes. No charts were available for review due to nonactive charts being stored at an off site location.

POLICIES REVIEWED: Policy I-05 (Important) "Informed Consent and Right to Refuse" is compliant with PBNDS 2008.

AMERICAN OVERSIGHT

Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	25

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during March 2018 site visit.

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is complaint with PBNS 2008.

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during March 2018 site visit.

POLICIES REVIEWED: Policy A-10 (Essential)"Procedure in the event of a Patient Death"; Policy G-11 (Important) "Care of the Terminally Ill"; Policy I-04 (Important) "End-of-Life Decision Making"

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on June 24-28, 2018. The audit consisted of a review of over 60 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees. Older medical charts were not accessible because they are not maintained on-site at the facility. At the current time, the facility moves any inactive ICE charts to STDC, IHSC facility, within a week due to lack of on-site storage space.

Facility Data:
Rio Grande Detention Center (RGDC) is a non-dedicated contracted detention facility located in Laredo, Texas. It is owned and operated by GEO Corporation. The facility houses a combination of US Marshal (USM) male and female prisoners and male ICE detainees. The facility consists of eight housing units, two of which are dedicated to ICE detainees.

Population Characteristics:
Total Inmate Capacity- 1900 (672 ICE detainees and 1228 US Marshal prisoners)
-Current total population-1859
---ICE - 734 (at the time of report facility had additional emergency beds added)
---USM - 1120 (70 females, 1050 males)
-Average Daily ICE Population for the last six months- 590
-The average ICE detainee stay is 7-15 days

--ACCREDITATIONS/INSPECTIONS:
-PBNDS 2008 (Nakamoto)- March 2019
-NCCHC - last completed in June 2018; next visit will be in 2020
-ACA- June 10, 2019
-ODO-June 10-13, 2019

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--MEDICAL CLINIC/INFIRMARY:
-The medical clinic is spacious with a large centralized nurse's station. There are three exam rooms, a dental suite, a dental procedure room with panoramic x-ray, a locked pharmacy, a locked medical records room and an urgent care suite.
-The urgent care suite has an emergency bag, a gurney, two AEDs, tank oxygen, portable suction, and an electrocardiogram. Emergency equipment is checked daily by the nursing staff.
-Connected to the medical clinic is a 15 bed infirmary. There are three negative pressure rooms and four mental health rooms with cameras.
-There is one suicide observation rooms located in the medical infirmary. The rooms have been modified to accommodate suicidal detainees and all potential harmful objects have been removed.

--MEDICAL STAFFING:

(b)(7)(E)

-The physician, LPCs and Nurse Practitioner all take call. The HSA reports that he can call LPCs in on the weekend as needed when appropriate for patient care needs.
-Staffing policy reviewed during the site visit; the policy was last reviewed by the facility in February 2019. The HSA reported participation in a quarterly meeting to discuss staffing needs.

AMERICAN OVERSIGHT

OTHER SUPPLEMENT INFO:
-All (100%) staff credential folders were reviewed. All folders were found to be in good order and well organized. All had current credentials that were from the State of Texas and a current Basic Life Support (BLS) card.
-The remaining RGDC Policy and Procedure Manual was reviewed. All policies reviewed were found to be consistent with PBNDS 2008 standards. The policies and procedures were last reviewed in February 2019.
-A training folder is maintained on all medical staff. Medical staff receive appropriate training for their position and have competencies documented annually. Staff also receives annual training on several topics including suicide prevention and intervention, the emergency plan, medication administration, dental screening, hunger strikes, mumps, varicella, measles cohorting, vaccination and PREA. Training folders were found to be well organized and up to date. The Registered Nurses who complete History and Physicals have documentation of training in their folders.

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Deficiencies for Areas Evaluated

--PBNDS 2008 DEFICIENCIES:
-No findings noted.

--QUALITY OF CARE ISSUES:
-20% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours. (Repeat Finding)
-0% of labs (HgAIC or lipids; labs for HTN or thyroid patients included)were drawn per the doctor's orders. (Repeat Finding)
-0% of routine labs had a report back that was acknowledged within seven days. (Repeat Finding)
-0% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment.(Repeat Finding)
-The two ER detainees could have received early intervention that might have prevented deterioration.
-100% of cases, the nursing staff did not follow the doctor's orders to aid with following the chronic care guidelines for HTN patients. (Repeat Finding)

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC Audit Tool.

PREVIOUS FINDINGS:
-10% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Health Assessment

See QMC Audit Tool.

Urgent Care (Sick Call)

See QMC Audit Tool.

PREVIOUS FINDINGS:
-10% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC Audit Tool.

Medication Administration Practices

See QMC Audit Tool.

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Continuity of Medication

See QMC Audit Tool.

PREVIOUS FINDINGS:
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake.
-In 10% of cases, the period of time from medication order to first dose exceeded 24 hours.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Mental Health Screen

See QMC Audit Tool.

Medical Recordkeeping Practices

See QMC Audit Tool.

Pregnant Women

Rio Grande Detention Facility only houses male ICE detainees.

Dental Care

See QMC Audit Tool.

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Acute Laboratory Testing

See QMC Audit Tool.

PREVIOUS FINDINGS:
-40% were routine labs and had a report back and acknowledged within seven days.
-50% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment.
-60% of the patients advised of laboratory results.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Diagnostic Services and Specialty Care Access

See QMC Audit Tool.

PREVIOUS FINDINGS:
-60% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.
-44% of charts demonstrated that the appointment was accomplished within 45 days of the order.
-25% of detainees were not re-evaluated for deterioration.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Mental Health Treatment Planning

See QMC Audit Tool.

Treatment of Disability

See QMC Audit Tool.

PREVIOUS FINDINGS:
-Two disabilities was not prominently displayed in the medical file.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Complaints and Grievances

See QMC Audit Tool.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC Audit Tool.

PREVIOUS FINDINGS:
-Two diabetic detainee did not have their blood sugar taken during the intake process.
-The physician ordered labs on all of the diabetic detainees. The nursing staff did not draw labs (HgAIC or lipids) per the doctor's orders.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Human Immunodeficiency Virus (HIV)

See QMC Audit Tool.

PREVIOUS FINDINGS:
-The CD4+ and viral load was not completed within 14 days.
-Detainee was not seen by HIV or ID Specialist within 30 days.
-Chest x-ray was not completed in 72 hours; it was completed eight days after intake.

Hypertension

See QMC Audit Tool.

PREVIOUS FINDINGS:
-One chart revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90 that did not include a treatment plan initiated within 14 days of identifications.
-80% of cases, the nursing staff did not follow the doctor's orders to aid with following the chronic care guidelines for HTN patients.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

Asthma

See QMC Audit Tool.

Seizure Disorder

See QMC Audit Tool.

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Recommendations

(b)(5)

Facility Actions

The HSA, Q&A Nurse, and the Warden were notified of all findings/deficiencies during the close-out interview. HSA obtained MedPAR access for additional nursing staff during site visit; FMC gave guidance for additional training and maintaining access. HSA and Q&A Nurse began discussion of revamping lab process to include a request from Wellpath Corporate office to begin a pilot program where a phlebotomist came over to draw labs at the facility to put in place for the labs. Clinical Director developed form for standing order set for use during intake for HTN and DM patients. FMC sent a close out summary of findings, recommendations and HSA plans to Laredo AFOD, CORs, SNA DFOD and SNA FOD.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (210) 283 (b)(6); (b)(7)(C)	Date Prepared: 11/05/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 507 (b)(6); (b)(7)(C)	Date Reviewed: 11/12/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 321 (b)(6); (b)(7)(C)	Date Approved: 11/12/2019
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (202) 507 (b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 11/12/2019

Recommendations:

(b)(5)

AMERICAN OVERSIGHT

ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan
(Follow up to the August 2017 FMC Site Visit)

Facility Name	**Rio Grande Detention Center**
Address (Street and Name)	**1001 San Rio Blvd.**
City, State and Zip Code	**Laredo, TX 78046**
County	**Webb County**
Date[s] of FMC Site Visit	**8/21/2017-8/23/2017**
Complete and Return to ICE HQ No Later Than: 30 days *To be Completed by DMD*	

Facility Corrective Action Plan Assigned to	**Field Office**

~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

Report produced on February 12, 2018

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Date of Final Submission:
12 February 2018

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the Field Office must contact the appropriate DMD staff member with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (August 2017 FMC site visit) Rio Grande Detention Center (SNA)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
[PBNDS 2008 Standard Deficiency] A health evaluation was performed greater than 14 days after arrival to the facility (Medical Care) (V) (J). **(Repeat Finding)**	(b)(5)	The Health Services Administrator (HSA) or designee will provide refresher training to the medical records clerk and health care providers on scheduling health assessments on new arrivals within 14 days of arrival. The data entry clerk will be retrained by March 1, 2018 on the requirements of scheduling and	Training with be completed by March 1, 2018. The Quality Assurance (QA) nurse will monitor the corrective action plan for a minimum of 60 days or until 100% compliance is achieved.

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		completing health assessments. The HSA/designee will monitor GEO track to verify compliance weekly for the next 60 days. Noncompliance will be reported during the department monthly meetings.	
[PBNDS 2008 Standard Deficiency] Inconsistent completion of dental exam within 14 days of arrival. (Dental Treatment)(V)(M). [CQI Finding] -33% of dental cases were not evaluated by qualified health professional within 48 hours of request. -One dental note did not describe findings, diagnosis, treatment and plans. -75% of detainees were not scheduled for follow-up dental treatment.	(b)(5)	The dentist or designee will provide refresher training to all medical professionals on completing dental screenings during the absence of dental personnel. Dental screenings have been added to all 14-day health appraisals. The dental assistant will conduct monthly audits on 10% of ICE dental cases to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] One detainee did not receive a documented mental health clinical assessment, treatment and follow-up plan.		The HSA or designee will provide refresher training to all staff on the requirements for timely mental health clinical assessment, treatment and follow-up by March 1, 2018. The mental health counselor will conduct monthly audits for the next 90 days or until	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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		100% compliance is achieved. Noncompliance will be reported during the department monthly meetings.	
[CQI Finding] An asthma chart was reviewed and the peak flow was not completed on the initial physical exam.	(b)(5)	The HSA or designee will provide refresher training to all staff on the requirements for asthma patients. Peak flows has been added to the intake screening the intake (*See* Attachment 1) and physician's chronic care forms (*See* Attachment 2). The comprehensive health assessment will be completed within 14 days of arrival. The Chronic Care nurse will conduct monthly audits for the next 90 days to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] 67% of routine labs did not have a report back and acknowledged within seven days. No time urgency noted on labs.		The HSA or designee will provide refresher training to staff on the requirements for time urgency on labs, diagnostic services, and specialty care. Chronic care forms have been revised and include a communication section. In the communication section, the physician documents lab and diagnostic exams (*See* Attachment 2).	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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[CQI Finding] 10% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment, and patients advised of laboratory results.	(b)(5)	The HSA or designee will provide refresher training to staff on the requirements for a response and acknowledgment of laboratory results by March 1, 2018. The Chronic Care nurse will conduct a chronic care audit on 5% of ICE chronic care charts to verify compliance. Results will be monitored by the HSA. The Chronic Care nurse will conduct monthly audits for the next 90 days to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] One diabetic detainee did not have his blood sugar taken during the intake process.		The HSA or designee will provide refresher training to staff on the requirements on blood sugar checks on intake process by March 1, 2018. A line item for blood sugar results has been added to the medical intake packet (*See* Attachment 1).	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] A disability was not prominently noted on a disabled detainee's record.		The HSA or designee will provide refresher training to staff on the recommendation of noting the disability on the problem list and/or sticker on the medical chart by March 1, 2018.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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[CQI Finding] 75% of charts reviewed by the FMC showed documented time urgency included on the order for specialty care or diagnostic services.	(b)(5)	The HSA will retrain the facility physician no later than March 1, 2018, on the recommended documentation of time urgency in specialty care or diagnostic services. The physician's chronic care forms have been updated and include time urgency on specialist consults (*See* Attachment 2).	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] One instance where a specialty appointment was not completed within ordered time frame.		The HSA or designee will provide refresher training to staff on the recommendation of tracking booking/scheduling of specialty appointments by March 1, 2018. A log will be created for ICE detainees that are referred to a specialty appointment (*See* Attachment 3).	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] A serum drug level was not ordered on a detainee taking anti-convulsant medication; this is a repeat finding from the last site visit. A seizure patient did not have a documented treatment plan.		The facility physician will be retrained by the HSA no later than March 1, 2018, on the requirements of serum drug level ordered on detainees taking anti-convulsant medications. The chronic care forms have been updated and include in the labs section an indicator for serum drug levels (*See* Attachment 4).	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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[CQI Finding] There was no consistency with blood pressure monitoring on detainees who had a history of HTN and presented with a high systolic blood pressure during intake. One patient received continuity of care with medications on intake, but labs were ordered over 45 days later. There was one chart that included a blood pressure check flowsheet on a detainee who was hypertensive, but the blood pressures where consistently high and there was no treatment plan identified for this patient (i.e. no change of medication). This chart had no time urgency noted on labs and there were no chronic care appointments or notes present in the chart for this patient.	(b)(5)	The HSA or designee will provide refresher training by March 1, 2018, to all staff, inclusive of the practitioners, on the treatment and monitoring of hypertension patients as recommended in the Hypertension Clinical Practice Guidelines. The Chronic Care nurse will conduct a chronic care audit on 5% of chronic care charts for the next 90 days to verify compliance or until 100% compliance is achieved. Results will be monitored by the HSA.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] One instance where MAR noted consecutive refusals of an antibiotic from a detainee. There was no documentation of the reason for the refusal and no documentation of a response from the clinician.	(b)(5)	The HSA or designee will provide refresher training to staff on the recommendation of documenting a rationale for refusals of medications by March 1, 2018. The Director of Nursing (DON) will conduct an audit on 5% of medical administration records for the	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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		next 90 days to verify compliance or until 100% compliance is maintained. Results will be monitored by the HSA.	
[CQI Finding] Two records were missing MARs that needed to be filed; the missing MARs were from the previous month.	(b)(5)	The HSA or designee will provide refresher training to all staff by March 1, 2018, on the organization and proper filing of medical information in the health care record. The HSA will verify all staff has received training by March 1, 2018 and that all staff has signed a training acknowledgement. The DON will review a minimum of 20 health care charts monthly for the next 90 days to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] 60% suicidal patients were not evaluated within 24 hours of identification.	(b)(5)	The HSA or designee will provide refresher training to all staff by March 1, 2018, on the requirement on initial evaluation of suicidal patients within 24 hours by a mental health professional or appropriately trained medical professionals as outlined in PBNDS 2008. The DON will review a minimum of 10 mental health care charts monthly for the next 90 days to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.

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[CQI Finding] 20% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.	(b)(5)	The HSA or designee will provide refresher training to all staff by March 1, 2018, on the criteria for recommending referrals of detainees with suicide risks to the psychiatrist. The DON will review a minimum of 10 mental health care charts monthly for the next 90 days to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018. The QA nurse will monitor the corrective action plan for a minimum of 90 days or until 100% compliance is achieved.
[CQI Finding] 20% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours (NCCHC Standard, J-E-07, Nonemergency Health Care Requests and Services, Compliance Indicators, #1)		The HSA or designee will provide refresher training to all staff by March 1, 2018, on the requirement of completing a sick call request within 72 hours (b)(7)(E) (b)(7)(E) The QA nurse will conduct monthly audits for the next 90 days on 10% of sick calls to verify compliance or until 100% compliance is achieved.	Training with be completed by March 1, 2018.
[CQI Finding] One detainee had medications that were not ordered in less than 24 hours from completion of the intake.		The HSA or designee will provide refresher training to all staff by March 1, 2018, on the requirements of ordering medications within 24 hours of the detainee's arrival to the facility. The QA nurse will conduct monthly audits for the next 90 days on 10% of ICE Chronic Care charts until 100% compliance is	Training with be completed by March 1, 2018.

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		achieved. Results will be monitored by the HSA.	
[CQI Finding] In 20% of cases, the period of time from medication order to first dose exceeded 24 hours.	(b)(5)	The HSA or designee will provide refresher training to all staff by March 1, 2018, on the requirements of ordering medications within 24 hours of the detainee's arrival to the facility. The QA nurse will conduct monthly audits for the next 90 days on 10% of Chronic Care charts until 100% compliance is achieved. Results will be monitored by the HSA.	Training with be completed by March 1, 2018.

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DHS-ICE-20-0618-A-001847

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
08/21/2017	02/21/2017	Rio Grande Detention Facility (RGDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	SNA AOR

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
612	612	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)	Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)
Address: 1001 San Rio Blvd. Laredo, TX 78046	Address: 1001 San Rio Blvd. Laredo, TX 78046

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 2008 DEFICIENCIES:
1) A chart consisted of a health evaluation that was not completed within 14 days of booking. (Medical Care) (V) (J).
2) Inconsistent completion of dental exam within 14 days of arrival. (Dental Treatment) (V) (M).

PREVIOUS FINDINGS (FEBRUARY 2017):
1) REPEAT-Several health appraisals were performed greater than 14 days after arrival to the facility (Medical Care) (V) (J).
2) RESOLVED-Medical grievances are not tracked and logged in a Detainee Grievance Log (Grievance System) (V) (E).

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
50	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is compliant with PBNDS 2008.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy I-05 (Important) "Informed Consent and Right to Refuse" is compliant with PBNDS 2008.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	17

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is complaint with PBNS 2008.

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy A-10 (Essential)"Procedure in the event of a Patient Death"; Policy G-11 (Important) "Care of the Terminally Ill"; Policy I-04 (Important) "End-of-Life Decision Making"

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on August 21-23, 2017. The audit consisted of a review of 75 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees. Older medical charts were not accessible because they are not maintained on-site at the facility. At the current time, the facility moves any inactive ICE charts to STDC, IHSC facility, within a week due to lack of on-site storage space.

Facility Data:
Rio Grande Detention Center (RGDC) is a non-dedicated contracted detention facility located in Laredo, Texas. It is owned and operated by GEO Corporation. The facility houses a combination of US Marshal (USM) male and female prisoners and male ICE detainees. The facility consists of eight housing units, two of which are dedicated to ICE detainees.

Population Characteristics:
Total Inmate Capacity- 1900 (672 ICE detainees and 1228 US Marshal prisoners)
-Current total population-1487
---ICE - 612
---USM - 875
-Average Daily ICE Population for the last six months- 528
-The average ICE detainee stay is 14 days

--ACCREDITATIONS/INSPECTIONS:
-PBNDS 2008 (Nakamoto)- March 2016
-NCCHC - last completed in June 2017
-ACA- April 2016

AMERICAN OVERSIGHT

--MEDICAL CLINIC/INFIRMARY:
-The medical clinic is spacious with a large centralized nurse's station. There are three exam rooms, a dental suite, a dental procedure room with panoramic x-ray, a locked pharmacy, a locked medical records room and an urgent care suite.
-The urgent care suite has an emergency bag, a gurney, two AEDs, tank oxygen, portable suction, and an electrocardiogram. Emergency equipment is checked daily by the nursing staff.
-Connected to the medical clinic is a 15 bed infirmary. There are two negative pressure rooms and four mental health rooms with cameras.
-There are two suicide observation rooms located in the medical infirmary. The rooms have been modified to accommodate suicidal detainees and all potential harmful objects have been removed.

--MEDICAL STAFFING:

(b)(7)(E)

OTHER SUPPLEMENT INFO:
-All (100%) staff credential folders were reviewed. All folders were found to be in good order and well organized. All had current credentials that were from the State of Texas and a current Basic Life Support (BLS) card.
-The remaining RGDC Policy and Procedure Manuals was reviewed. All policies reviewed were found to be consistent with PBNDS 2008 standards. The policies and procedures were last reviewed in December 2016.

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-A training folder is maintained on all medical staff. Medical staff receive appropriate training for their position and have competencies documented annually. Staff also receives annual training on several topics including suicide prevention and intervention, hunger strikes and PREA. Training folders were found to be well organized and up to date. The Registered Nurse who completes History and Physicals has documentation of training in his folder.

Deficiencies for Areas Evaluated

--PBNDS 2008 DEFICIENCIES:
-A chart consisted of a health evaluation that was not completed within 14 days of booking.
-Detainees not consistently receiving a dental exam within 14 days of booking.

--QUALITY OF CARE ISSUES:
-60% suicidal patients were not evaluated within 24 hours of identification.
-20% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.
-20% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours (NCCHC Standard, J-E-07, Nonemergency Health Care Requests and Services, Compliance Indicators, #1)
-One MAR noted consecutive refusals of an antibiotic from a detainee. There was no documentation of the reason for the refusal and no documentation of a response from the clinician.
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake.
-In 20% of cases, the period of time from medication order to first dose exceeded 24 hours.
-67% of routine labs did not have a report back and acknowledged within seven days. No time urgency noted on labs.
-10% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment, and patients advised of laboratory results.
-One of the detainees did not receive a documented mental health clinical assessment, treatment and follow-up plan.

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-One disability was not prominently displayed in the medical file.
-One diabetic detainee did not have his blood sugar taken during the intake process.
-There was no consistency with blood pressure monitoring on detainees who had a history of HTN and presented with a high systolic blood pressure during intake.
-One patient received continuity of care with medications on intake, but labs were ordered over 45 days later.
-One detainee did not have a peak flow measurement completed during the initial physical exam.
-A serum drug level was not ordered on a detainee taking anti-convulsant medication; this is a repeat finding from the last site visit.
-A seizure patient did not have a documented treatment plan.
-75% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.
-One detainee did not receive a specialty appointment within ordered time frame.
Two records were missing MARs that needed to be filed; the missing MARs were from the previous month.
-33% of dental cases were not evaluated by qualified health professional within 48 hours of request.
-One dental note did not describe findings, diagnosis, treatment and plans.
-75% of detainees were not scheduled for follow-up dental treatment.
-There was one chart that included a blood pressure check flowsheet on a detainee who was hypertensive, but the blood pressures where consistently high and there was no treatment plan identified for this patient (i.e. no change of medication). This chart had no time urgency noted on labs and there was no chronic care appointments or notes present in the chart for this patient.

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Suicide Screening

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is compliant with PBNDS 2008.

RGDC performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.

In the past six months there have been 11 detainees on suicide watch. Five charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose as other charts were already moved to off-site location.
-2 of 5 (40%) suicidal patients were evaluated by the physician within 24 hours of identification. The other patients were seen within two days and each of these occurrences happened when the detainees were placed on watch going into the weekend. The HSA reports that they are currently working with CCS to develop a weekend on-call system for the mental health professionals.
-4 of 4 (100%) were evaluated by a qualified mental health professional every day during the work week (Monday - Friday) and by a nurse on the weekend.
-During the entirety of the suicide watch the detainees were monitored continuously by a detention officer who documented every 15 minutes.
-1 of 5 (20%) of the chart audits noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch. The detainee had a history of seizures, mental health, behavior problems and cardiac arrhythmias. There was no serum Dilantin levels drawn on the patient and he had 15 medication refusals. The detainee was seen later in the ER where labs were ordered. The patient was later placed on suicide watch and not seen within 24 hours by a mental health professional due to the weekend. He did not receive a referral for the psychiatrist. During the audit, FMC noted a trend that none of the suicide watches were referred to the psychiatrist. The trend was brought to the HSA's attention to determine the criteria for referral of suicidal patients to the psychiatrist.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS:
-60% suicidal patients were not evaluated within 24 hours of identification.
-20% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.

Health Assessment

POLICIES REVIEWED: Policy E-04 (Essential) "Initial Health Assessment" is compliant with PBNDS 2008.

Twenty charts were reviewed using the IHSC Quality of Care Audit Tool.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-20 of 20 (100%) had a PPD placed during the initial intake screening and was read within 48-72 hours.
-19 of 19 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-19 of 19 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-18 of 20 (90%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, health appraisals are completed by the physician, NP or (b)(7)(E) trained RN.

PREVIOUS FINDINGS (February 2017): REPEAT: Several health appraisals were performed greater

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than 14 days after arrival to the facility. (Medical Care) (V) (J)

CURRENT FINDINGS:
-One chart consisted of a health evaluation that was not completed within 14 days of booking.

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy E-07 (essential) "Non-Emergency Health Care Requests and Services" is compliant with PBNDS 2008.

According to RGDC nursing staff, the sick call process is initiated by a detainee filling out a paper sick call request. Slips are picked up daily and triaged by the nursing staff. Non-urgent requests are seen by nurses who use clinical protocols and document sick call encounters on standard forms called problem-oriented records, which are available for a large number of medical complaints. Per RGDC policy, all oral and written requests for health care will be triaged within 24 hours by a qualified health care professional. When indicated, the patient will be seen by a qualified health care professional at the next available sick call or clinician's clinic, usually within 24 hours (or up to 72 hours on weekends or holidays).

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool used to evaluate this area.

-8 of 10 (80%) had a timely and appropriate evaluation by nursing staff (seen within 72 hours). One detainee was seen within four days and the other detainee was seen within five days.
-10 of 10 (100%) encounters demonstrated that care was delivered within the scope of the nurse's license.
-10 of 10 (100%) of sick call encounters had vital signs documented during the nurse's assessment.
-6 of 6 (100%) had a nursing referral to a medical provider within 24 hours when appropriate.
-3 of 3 (100%) of detainees referred to a medical provider had the assessment and plan documented within the note.

PREVIOUS FINDINGS (February 2017): REPEAT: Half of the reviewed encounters received a timely and appropriate evaluation by nursing staff (seen within 72 hours).

CURRENT FINDINGS:
-20% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

POLICIES REVIEWED: Policy E-08 (Essential) "Emergency Services" is complaint with PBNDS 2008.

There were ten medical charts reviewed during the site visit using the IHSC Quality of Care Audit Tool.
-10 of 10 (100%) had an outbound progress note.
-0 of 10 (100%) showed evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-10 of 10 (100%) had discharge documentation from the hospital and an inbound assessment.
-9 of 9 (100%) had inbound assessments.
-8 of 8 (100%) demonstrated that the hospital's recommendations were acknowledged and carried out.

PREVIOUS FINDINGS (February 2017): During the time of the February 2017 audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP.

CURRENT FINDINGS:
-During the time of this site visit. The HSA was unable to show the evidence as indicated in the December 2016 UCAP.

Medication Administration Practices

POLICIES REVIEWED: Policy D-01 (Essential) "Pharmaceutical Operations" and Policy D-02

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(Essential)"Medication Services" are compliant with PBNDS 2008.

RGDC contracts with Correct RX for pharmaceutical services. Orders are placed on a daily basis and as needed. Medication ordered prior to 3 PM are received on the next day.
Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

-RGDC policy specifies that a patient should be referred to the responsible physician after three refusals of any medication. Policy also indicates that when certain high risk medications (i.e., antiepileptics, antibiotics, anticoagulants, antihypertensives, anti-retrovirals/HIV, cardiac medications, hypoglycemic medications, pulmonary medications, or psychotrophic medications) are refused for three or more doses that a mental health referral also be completed.
-One MAR noted consecutive refusals of an antibiotic from a detainee. There was no documentation for the reason for the refusal and no documentation of a response from the clinician.
-Approximately 80% of patients are on self-administered medication ordered by a provider.
-Two records were missing MARs that needed to be filed; the missing MARs were from the previous month.
-Over the Counter (OTC) medications are provided by both medical and can be purchased at the commissary.
At this site visit, active charts and inactive charts were reviewed. Some of the inactive charts were found to be missing MARs.

PREVIOUS FINDINGS (February 2017): During the time of the audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP.

CURRENT FINDINGS:
-During the time of the site visit, HSA was unable to show evidence that QA monitoring or staff education had been does as indicated in the December 2016 UCAP.
-One MAR noted consecutive refusals of an antibiotic from a detainee. There was no documentation of the reason for the refusal and no documentation of a response from the clinician.
-Two records were missing MARs that needed to be filed; the missing MARs were from the previous month.

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Continuity of Medication

POLICIES REVIEWED: Policy E-12 (Essential) "Continuity of Care During Incarceration" is compliant with PBNDS 2008.

When a detainee arrives to the facility with chronic medications the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-9 of 10 (90%) charts showed that medications were ordered in less than 24 hours from completion of the intake. The one chart showed that the medications were ordered within two days.
-In 8 of 10 (80%) cases, the period of time from order to first dose was less than 24 hours. One chart indicated two days and the other chart reviewed indicated three days and had a note stating that the medication was out of stock.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS:
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake.
-In 20% of cases, the period of time from medication order to first dose exceeded 24 hours.

Mental Health Screen

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and evaluation (MH Services Provided)" is compliant with PBNDS 2008.

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool.
-10 of 10 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy H-01 (Essential) "Health Record Format and Contents" is compliant with PBNDS 2008.

All charting at Rio Grande Detention Center is done on paper. Medical records are kept in a locked room to which only medical personnel have access to. At the current time, there are no plans to obtain an electronic medical record.

Ten charts were reviewed using the IHSC Quality of Care Tool. Charts were found to be complete and orderly.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Pregnant Women

Rio Grande Detention Facility only houses male ICE detainees.

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Dental Care

POLICIES REVIEWED: Policy E-06 (Essential) "Oral Care" is compliant with PBNDS 2008.

There is a vacancy at Rio Grande Detention Facility for a dentist and a dental assistant that opened approximately 1.5 weeks before the site visit. Prior to the resignation of the dentist, the outlined process was for the detainees to be screened by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request The dentist evaluated the patient the following working day and decided if treatment is appropriate. During the last site visit, the treatment was scheduled within one week.

Seven charts were reviewed using the IHSC Quality of Care Audit Tool.
-7 of 7 (100%) were screened for symptoms during the intake process.
-4 of 6 (67%) were evaluated by a qualified health professional within 48 hours of request. There were two cases that were seen within three to four days of request.
-6 of 7 (86%) dental notes reviewed described findings, diagnosis, treatment and plans. The dental note states that the detainee needed to be seen by the dentist, but the dentist resigned and the detainee was not seen. The same detainee had a sick call request that was not addressed. At the time of the site visit, there was no plan in place for dental care of detainees during the hiring process of a new dentist.
-1 of 4 (25%) were scheduled for follow-up treatment as recommended. Only one chart had completed dental screening and follow-up treatment as recommended.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS:
-33% of dental cases were not evaluated by qualified health professional within 48 hours of request.
-One dental note did not describe findings, diagnosis, treatment and plans.
-75% of detainees were not scheduled for follow-up dental treatment.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy D-04 (Important) "Diagnostic Services" is compliant with PBNDS 2008. Labcorp is contracted to pick up and process the labs collected at the facility. For STAT labs, Laredo Medical Center is utilized.

Ten charts were reviewed. The IHSC Quality of Care Tool was used to evaluate these records.

-3 of 9 (33%) were routine labs and had a report back and acknowledged within seven days. No time urgency noted on labs.
-9 of 10(90%) had report back within 24 hours, as appropriate, for acute labs or within seven days for routine labs
-9 of 10 (90%) charts had clinical acknowledgment.
-9 of 10 (90%) charts had an appropriate clinical response. The detainee didn't have a chronic care appointment or note.
-9 of 9 (100%) of the patients were advised of laboratory results.

PREVIOUS FINDINGS (February 2017):
1) 40% of lab work reviewed by the FMC did not have an appropriate clinical response.
2) 80% of charts did not show documentation that the detainee was notified of lab results.

CURRENT FINDINGS:
-67% of routine labs did not have a report back and acknowledged within seven days. No time urgency noted on labs.
-10% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment, and patients advised of laboratory results.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy D-05 (Important) "Hospital and Specialty Care" is compliant with PBNDS 2008.

Eight charts were available for the review using the IHSC Quality of Care Tool.

-2 of 8 (25%) had a documented time urgency included on the order for specialty care or diagnostic services.
-7 of 8 (87%) charts demonstrated that the appointment was accomplished within 45 days of the order. Detainee did not received an orthopedic appointment.
-7 of 7 (100%) of charts reflect the facility clinician acknowledgment of the specialist's report in the medical record within seven days of the date the service was performed.

PREVIOUS FINDINGS (February 2017): There were no charts available for review. At the time of this audit, the HSA was unable to show evidence that QA monitoring has yet been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

CURRENT FINDINGS:
-During the current site visit, the evidence of the QA monitoring was not available.
-75% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.
-One detainee did not receive a specialty appointment within ordered time frame.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake process. Detainees who screen positive are referred to a mental health provider (LPC) and are generally seen on the next day.

Ten records were reviewed using the IHSC Quality of Care Tool.
-9 of 10 (90%) had a clinical assessment, treatment and follow-up plan documented. One of the

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detainees had three anxiety attacks within a six day time-frame, concern of suicide risk noted by security, reports of hitting his head on the wall and was eventually put on suicide watch. He was seen by the LPC, but no referral, clinical assessment, treatment or follow-up plan from a psychiatrist.
-5 of 5 (100%) patients reviewed had a treatment plan updated at a minimum of every 90 days. The other mental health notes reviewed were all initial referrals and new additions to the mental health caseload.

PREVIOUS FINDINGS (February 2017): No findings noted.

CURRENT FINDINGS:
-One of the detainees did not receive a documented mental health clinical assessment, treatment and follow-up plan.

Treatment of Disability

POLICIES REVIEWED: POLICY G-02 (Essential) "Patients with Special Health Needs";Policy G-10 "Aids to Impairment" is compliant with PBNDS 2008.

All dorms in RGDC are wheelchair accessible. The facility has a TTY phone available. The facility also has walkers, wheelchairs and canes available.

At the time of this audit, there was only two detainees with documented disabilities. These records were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-1 of 2 (50%) had the disability prominently displayed in the medical file. There was a detainee who used a cane and wore diabetic shoes and the disability was documented in the record, but not prominently displayed.
-2 of 2 (100%) detainees were assessed for assistance with activities of daily living (ADL) upon identification of disability and appropriate accommodation orders were entered.

PREVIOUS FINDINGS (February 2017): No findings.

CURRENT FINDINGS:
-One disability was not prominently displayed in the medical file.

Complaints and Grievances

POLICIES REVIEWED: Policy A-11 (Essential) "Grievance Mechanism for Health Complaints" is complaint with PBNDS 2008.

Per HSA, all dorms have access to grievance forms and a drop box labeled for this purpose. The grievance officers picks them up and reviews them daily. All medical grievances are placed in the HSA's mailbox. The HSA is then responsible for answering all medical grievances.

During the site visit, FMC reviewed the Detainee Grievance Log using the IHSC Quality of Care Audit Tool. The review of the log does not show any possible barriers to care or repetitive concerns that could affect clinical care. There were no medical grievances submitted over the past three months.

PREVIOUS FINDINGS (February 2017): RESOLVED-Medical grievances were not tracked and logged in a Detainee Grievance Log (Grievance System) (V) (E).

CURRENT FINDINGS: At the time of this audit, there were no grievances.

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Diabetes

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is complaint with PBNDS 2008.

Two active diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose; no other charts were available for reasons specified earlier in the report.

-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of diabetes.

-1 of 2 (50%) had a blood sugar measured at intake. No accucheck was documented in the file.
-2 of 2 (100%) were seen for chronic care by a medical provider within 14 days.
-2 of 2 (100%) had a baseline HgA1C performed within the first 30 days.
-2 of 2 (100%) had lipids measured within one year.
-2 of 2 (100%) patients were followed every 90 days with appropriate vital signs.
-1 of 1 (100%) were prescribed aspirin as clinically indicated.
-1 of 1 (100%) charts demonstrated a degree of control (goal GgbA1C<8.0) documented.
-2 of 2 (100%) charts demonstrated a strategy to attain diabetes control documented in HgbA3C above the goal.

PREVIOUS FINDINGS (February 2017):
-Intake blood sugars were not consistently recorded on detainees claiming to have diabetes.
-One diabetic detainee was not seen for chronic care within 14 days.
-Baseline HgA1C lab work was not done within 30 days of arrival on all diabetic charts reviewed.

CURRENT FINDINGS:
-One diabetic detainee did not have his blood sugar taken during the intake process.

Human Immunodeficiency Virus (HIV)

At the time of this audit, RGDC had no ICE detainees documented as having HIV and because only active charts are maintained on site, there were no files to review. For this reason, the IHSC Quality of Care Audit Tool designed for this purpose was not used.

-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of HIV.

PREVIOUS FINDINGS (February 2017): No findings.

CURRENT FINDINGS: No findings due to no charts being present to review. RGDC staff reported that the facility has not had any HIV detainees since the last audit.

Hypertension

Ten charts of hypertensive detainees were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.

-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of hypertension.

-10 of 10 (100%) had a documented blood pressure on the medical intake.
-10 of 10 (100%) detainees were seen by a medical provider within the first 14 days at the facility.
-9 of 10 (90%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90 that included a treatment plan initiated within 14 days of identifications.
-7 of 10 (70%) cases, it appeared that a chronic disease guideline for HTN, which included

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obtaining baseline lab work, was followed.

PREVIOUS FINDINGS (February 2017):
-One detainee with hypertension was not seen for chronic care within 14 days.
-Two hypertension charts reviewed were not seen for chronic care and care was not consistent with clinical practice guidelines. Lab work, EKG, blood pressure monitoring were not ordered.

CURRENT FINDINGS:
-There was no consistency with blood pressure monitoring on detainees who had a history of HTN and presented with a high systolic blood pressure during intake.
-There was one chart that included a blood pressure check flowsheet on a detainee who was hypertensive, but the blood pressures where consistently high and there was no treatment plan identified for this patient (i.e. no change of medication). This chart had no time urgency noted on labs and there was no chronic care appointments or notes present in the chart for this patient.
-One patient received continuity of care with medications on intake, but labs were ordered over 45 days later.

Asthma

Five charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of asthma.
-5 of 5 (100%) were seen for chronic care by a medical provider within 14 days of illness identification. All others left the facility prior to day 14 and before being seen by a medical provider.
-4 of 5 (80%) had a peak flow measurement completed during the initial physical exam.
-4 of 4 (100%) had a peak flow completed at the chronic care visit or within the last three months.
-5 of 5 (100%) showed disease management consistent with BOP clinical practice guidelines.

PREVIOUS FINDINGS (February 2017): No findings noted. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

CURRENT FINDINGS:
-At the time of this audit, the HSA was not able to show evidence of QA monitoring or staff education as indicated in the December 2016 UCAP.
-One detainee did not have a peak flow measurement completed during the initial physical exam.

Seizure Disorder

One chart was reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.

-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of seizures.

-1 of 1 (100%) had an appropriate neurological assessment completed at the initial physical exam.
-1 of 1 (100%) were seen for chronic care by a medical provider within 14 days of illness identification.
-0 of 1 (0%) had serum drug levels ordered. In this case the detainee was taking Dilantin prior to arrival and no labs were ordered. The patient had 15 documented medication refusals. The patient was admitted to the ER later during his stay at the facility and labs were obtained during that visit.
-0 of 1 (0%) had an established treatment plan. No treatment care plan was found in the medical record.
-1 of 1 (100%) had a order for a bottom bunk.

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PREVIOUS FINDINGS (February 2017):
-The issue of obtaining a complete neurological history on seizure patients is a repeat finding. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.
-One seizure patient was not seen for chronic care within 14 days of arrival.
-A serum drug level was not ordered on a detainee taking anticonvulsant medication.

CURRENT FINDINGS:
-The HSA was unable to show evidence that QA monitoring or staff education was done as indicated in December 2016 UCAP.
-The chart available for review showed that serum drug levels were not obtained on the detainee who was taking anticonvulsant medications. There were documented refusals in the chart for the medication and the patient was later admitted to the ER where serum levels were taken at that time.
-This detainee did not have a documented treatment plan.

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Recommendations

(b)(5)

Facility Actions

The HSA and the Warden were notified of all findings/deficiencies during the close-out interview. Conducted a close-out meeting with Laredo AFOD, CORs, SDDOs at the Laredo Field Office to discuss and give a summary of findings.

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Additional Comments

Since site visit report, dental provider has been hired. Facility continues to work on developing model for weekend mental health coverage.

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (210) 283-(b)(6); (b)(7)(C)	Date Prepared: 10/18/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 507-(b)(6); (b)(7)(C)	Date Reviewed: 11/20/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 321-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Regional Field Medical Coordinator
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Signature: KARLY A LUCERO Digitally signed by KARLY A LUCERO DN: c=US, o=U.S. Government, ou=Department of Homeland Security, ou=ICE, ou=People, cn=KARLY A LUCERO, 0.9.2342.19200300.100.1.1=0387578289.ICE.2 Date: 2017.12.21 15:39:17 -07'00'	**Final Approval Date:** 12/21/2017

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
03/20/2018	08/21/2017	Rio Grande Detention Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	SNA AOR

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
636	636	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)	Phone Number: +1 (956) 718 (b)(6); (b)(7)(C)
Address: 1001 San Rio Blvd. Laredo, TX 78046	Address: 1001 San Rio Blvd. Laredo, TX 78046

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

None

PREVIOUS FINDINGS (AUGUST 2017):

1) Resolved-A chart consisted of a health evaluation that was not completed within 14 days of booking. (Medical Care) (V) (J).
2) Resolved-Only one detainee received dental screening; an initial dental screening exam shall be performed within 14 days of the detainee's arrival. (Dental Treatment) (V) (M).

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
49	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is compliant with PBNDS 2008.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
1	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit. Five declared hunger strikes. Four of the five charts were available for review due to nonactive charts being stored at an off site location.

POLICIES REVIEWED: Policy I-05 (Important) "Informed Consent and Right to Refuse" is compliant with PBNDS 2008.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	37

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is complaint with PBNS 2008.

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during February 2017 site visit.

POLICIES REVIEWED: Policy A-10 (Essential)"Procedure in the event of a Patient Death"; Policy G-11 (Important) "Care of the Terminally Ill"; Policy I-04 (Important) "End-of-Life Decision Making"

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on March 20-23, 2018. The audit consisted of a review of over 80 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees. Older medical charts were not accessible because they are not maintained on-site at the facility. At the current time, the facility moves any inactive ICE charts to STDC, IHSC facility, within a week due to lack of on-site storage space.

Facility Data:
Rio Grande Detention Center (RGDC) is a non-dedicated contracted detention facility located in Laredo, Texas. It is owned and operated by GEO Corporation. The facility houses a combination of US Marshal (USM) male and female prisoners and male ICE detainees. The facility consists of eight housing units, two of which are dedicated to ICE detainees.

Population Characteristics:
Total Inmate Capacity- 1900 (636 ICE detainees and 1113 US Marshal prisoners)
-Current total population-1749
---ICE - 636
---USM - 1113 (54 females, 1059 males)
-Average Daily ICE Population for the last six months- 577
-The average ICE detainee stay is 14 days

--ACCREDITATIONS/INSPECTIONS:
-PBNDS 2008 (Nakamoto)- March 2018
-NCCHC - last completed in June 2017
-ACA- April 2016

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--MEDICAL CLINIC/INFIRMARY:
-The medical clinic is spacious with a large centralized nurse's station. There are three exam rooms, a dental suite, a dental procedure room with panoramic x-ray, a locked pharmacy, a locked medical records room and an urgent care suite.
-The urgent care suite has an emergency bag, a gurney, two AEDs, tank oxygen, portable suction, and an electrocardiogram. Emergency equipment is checked daily by the nursing staff.
-Connected to the medical clinic is a 15 bed infirmary. There are two negative pressure rooms and four mental health rooms with cameras.
-There are two suicide observation rooms located in the medical infirmary. The rooms have been modified to accommodate suicidal detainees and all potential harmful objects have been removed.

--MEDICAL STAFFING:
(b)(7)(E)

-The physician, LPCs and Nurse Practitioner all take call. The HSA reports that she calls LPCs in on the weekend as needed when appropriate for patient care needs.
-Staffing policy reviewed during the site visit; the policy was last reviewed by the facility in December 2017. The HSA reported participation in a quarterly meeting to discuss staffing needs. (b)(7)(E)
(b)(7)(E)
(b)(7)(E)

OTHER SUPPLEMENT INFO:

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-All (100%) staff credential folders were reviewed. All folders were found to be in good order and well organized. All had current credentials that were from the State of Texas and a current Basic Life Support (BLS) card.
-The remaining RGDC Policy and Procedure Manual was reviewed. All policies reviewed were found to be consistent with PBNDS 2008 standards. The policies and procedures were last reviewed in December 1, 2017.
-A training folder is maintained on all medical staff. Medical staff receive appropriate training for their position and have competencies documented annually. Staff also receives annual training on several topics including suicide prevention and intervention, hunger strikes and PREA. Training folders were found to be well organized and up to date. The Registered Nurse who completes History and Physicals has documentation of training in his folder.

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Deficiencies for Areas Evaluated

--PBNDS 2008 DEFICIENCIES:
-No findings noted.

--QUALITY OF CARE ISSUES:
-10% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch. (Repeat Finding)
-10% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours. (Repeat Finding)
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake. (Repeat Finding)
-In 10% of cases, the period of time from medication order to first dose exceeded 24 hours. (Repeat Finding)
-Two disabilities was not prominently displayed in the medical file. (Repeat Finding)
-Two diabetic detainee did not have his blood sugar taken during the intake process. (Repeat Finding)
-0% of labs (HgAIC or lipids)were drawn per the doctor's orders.
-40% of routine labs had a report back that was acknowledged within seven days. (Repeat Finding)
-50% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment.(Repeat Finding)
-60% of the patients advised of laboratory results.(Repeat Finding)
-60% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.(Repeat Finding)
-44% of charts demonstrated that the specialty appointment was accomplished within 45 days of the order.(Repeat Finding)
-25% of detainees were not re-evaluated for deterioration.
-One chart revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90 that included a treatment plan initiated within 14 days of identifications. (Repeat Finding)
-80% of cases, the nursing staff did not follow the doctor's orders to aid with following the chronic care guidelines for HTN patients. (Repeat Finding)
-The CD4+ and viral load was not completed within 14 days on an HIV patient.
-HIV detainee was not seen by HIV or ID Specialist within 30 days.
-Chest x-ray was not completed in 72 hours on one HIV detainee; it was completed eight days after intake.

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Suicide Screening

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is compliant with PBNDS 2008.

RGDC performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.

In the past six months there have been 20 detainees on suicide watch. Five charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose as other charts were already moved to off-site location.
-10 of 10 (100%) suicidal patients were evaluated by the physician within 24 hours of identification. The HSA reports that she is able to call in the mental health professionals as needed on the weekend.
-10 of 10 (100%) were evaluated by a qualified mental health professional every day during the work week (Monday - Friday) and by a nurse on the weekend.
-10 of 10 (100%) of charts demonstrated that during the entirety of the suicide watch the detainees were monitored continuously by a detention officer who documented every 15 minutes. The documentation of the medical checks are in the record.
-1 of 10 (10%) of the chart audits noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch. The detainee had a history of mental health and reported taking psychiatric medications. He went on suicide watch three days after admission to the facility. An appointment was scheduled with the psychiatrist seven days after his admission and the clinic was canceled. The detainee was seen by the psychiatrist thirteen days after admission and ten days after going on suicide watch.

FINDINGS
-10% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-60% suicidal patients were not evaluated within 24 hours of identification.
-20% of the charts audited noted that earlier intervention could possibly have prevented deterioration to the point of need for suicide watch.

Health Assessment

POLICIES REVIEWED: Policy E-04 (Essential) "Initial Health Assessment" is compliant with PBNDS 2008.

Twenty charts were reviewed using the IHSC Quality of Care Audit Tool.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-20 of 20 (100%) had a PPD placed during the initial intake screening and was read within 48-72 hours.
-20 of 20 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-20 of 20 (100%) received timely follow-up for significant findings of acute or chronic

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conditions.
-20 of 20 (100%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, health appraisals are completed by the physician, NP or (b)(7)(E) trained RN.

PREVIOUS FINDINGS (August 2017): One health appraisals were performed greater than 14 days after arrival to the facility. (Medical Care) (V) (J)

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy E-07 (essential) "Non-Emergency Health Care Requests and Services" is compliant with PBNDS 2008.

According to RGDC nursing staff, the sick call process is initiated by a detainee filling out a paper sick call request. Slips are picked up daily and triaged by the nursing staff. Non-urgent requests are seen by nurses who use clinical protocols and document sick call encounters on standard forms called problem-oriented records, which are available for a large number of medical complaints. Per RGDC policy, all oral and written requests for health care will be triaged within 24 hours by a qualified health care professional. When indicated, the patient will be seen by a qualified health care professional at the next available sick call or clinician's clinic, usually within 24 hours (or up to 72 hours on weekends or holidays).

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool used to evaluate this area.

-9 of 10 (100%) had a timely and appropriate evaluation by nursing staff (seen within 72 hours). The detainee was seen within five days.
-10 of 10 (100%) encounters demonstrated that care was delivered within the scope of the nurse's license.
-10 of 10 (100%) of sick call encounters had vital signs documented during the nurse's assessment.
-3 of 3 (100%) had a nursing referral to a medical provider within 24 hours when appropriate.
-3 of 3 (100%) of detainees referred to a medical provider had the assessment and plan documented within the note.

FINDINGS
-10% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-20% of detainees did not receive a timely and appropriate evaluation by nursing staff within 72 hours.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

POLICIES REVIEWED: Policy E-08 (Essential) "Emergency Services" is complaint with PBNDS 2008.

Seven charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose as other charts were already moved to off-site location.

-7 of 7 (100%) had an outbound progress note.
-0 of 7 (100%) showed evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-7 of 7 (100%) had discharge documentation from the hospital and an inbound assessment.
-7 of 7 (100%) had inbound assessments.
-7 of 7 (100%) demonstrated that the hospital's recommendations were acknowledged and carried out.

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PREVIOUS FINDINGS (August 2017):
-During the time of this site visit, the HSA was unable to show the evidence as indicated in the December 2016 UCAP.

Medication Administration Practices

POLICIES REVIEWED: Policy D-01 (Essential) "Pharmaceutical Operations" and Policy D-02 (Essential)"Medication Services" are compliant with PBNDS 2008.

RGDC contracts with Correct RX for pharmaceutical services. Orders are placed on a daily basis and as needed. Medication ordered prior to 3 PM are received on the next day.
Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

-RGDC policy specifies that a patient should be referred to the responsible physician after three refusals of any medication. Policy also indicates that when certain high risk medications (i.e., antiepileptics, antibiotics, anticoagulants, antihypertensives, anti-retrovirals/HIV, cardiac medications, hypoglycemic medications, pulmonary medications, or psychotrophic medications) are refused for three or more doses that a mental health referral also be completed.
-There were no MARs that showed consecutive refusals, blanks or no shows.
-Approximately 80% of patients are on self-administered medication ordered by a provider.
-There were no records with missing MARs from the previous month.
-Over the Counter (OTC) medications are provided by both medical and can be purchased at the commissary.
-At this site visit, active charts and inactive charts were reviewed.

PREVIOUS FINDINGS (August 2017):
-During the time of the site visit, HSA was unable to show evidence that QA monitoring or staff education had been does as indicated in the December 2016 UCAP.
-One MAR noted consecutive refusals of an antibiotic from a detainee. There was no documentation of the reason for the refusal and no documentation of a response from the clinician.
-Two records were missing MARs that needed to be filed; the missing MARs were from the previous month.

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Continuity of Medication

POLICIES REVIEWED: Policy E-12 (Essential) "Continuity of Care During Incarceration" is compliant with PBNDS 2008.

When a detainee arrives to the facility with chronic medications the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-9 of 10 (90%) charts showed that medications were ordered in less than 24 hours from completion of the intake. The one chart showed that the order for the medication was entered 13 days after admission. HSA reports that detainees with mental health histories have to wait to see the LPC before they see the psychiatrist in their current process.
-In 9 of 10 (90%) cases, the period of time from order to first dose was less than 24 hours.

FINDINGS:
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake.
-In 10% of cases, the period of time from medication order to first dose exceeded 24 hours.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-One detainee had medications that were not ordered in less than 24 hours from completion of the intake.
-In 20% of cases, the period of time from medication order to first dose exceeded 24 hours.

Mental Health Screen

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and evaluation (MH Services Provided)" is compliant with PBNDS 2008.

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool.
-10 of 10 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (August 2017): No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy H-01 (Essential) "Health Record Format and Contents" is compliant with PBNDS 2008.

All charting at Rio Grande Detention Center is done on paper. Medical records are kept in a locked room to which only medical personnel have access to. At the current time, there are no plans to obtain an electronic medical record.

Ten charts were reviewed using the IHSC Quality of Care Tool. Charts were found to be complete and orderly.

Incidental finding/observation: MedPARs are not being submitted timely.

PREVIOUS FINDINGS (February 2017): No findings noted.

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Pregnant Women

Rio Grande Detention Facility only houses male ICE detainees.

Dental Care

POLICIES REVIEWED: Policy E-06 (Essential) "Oral Care" is compliant with PBNDS 2008.

The vacancy for a dentist and a dental assistant was filled after the last site visit; there is a current vacancy for a part-time dentist. The outlined process includes the detainees being screened by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request. The dentist evaluates the patient the following working day and decided if treatment is appropriate.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool.
-10 of 10 (100%) were screened for symptoms during the intake process.
-10 of 10 (100%) were evaluated by a qualified health professional within 48 hours of request.
-10 of 10 (100%) dental notes reviewed described findings, diagnosis, treatment and plans.
-10 of 10 (100%) were scheduled for follow-up treatment as recommended.

PREVIOUS FINDINGS (August 2017):
-33% of dental cases were not evaluated by qualified health professional within 48 hours of request.
-One dental note did not describe findings, diagnosis, treatment and plans.
-75% of detainees were not scheduled for follow-up dental treatment.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy D-04 (Important) "Diagnostic Services" is compliant with PBNDS 2008. Labcorp is contracted to pick up and process the labs collected at the facility. For STAT labs, Laredo Medical Center is utilized.

Ten charts were reviewed. The IHSC Quality of Care Tool was used to evaluate these records.

-4 of 10 (40%) had blood drawn within one business day of ordered date.
-5 of 10 (50%) had report back within 24 hours, as appropriate, for acute labs or within seven days for routine labs. Some of the labs for chronic care patients (diabetic, HTN, gout, thyroid, HIV detainees) that the physician order were not completed and the results were not in the chart. When the FMC checked, MedPARs were not entered for the labs.
-5 of 10 (50%) charts had clinical acknowledgment.
-5 of 10 (50%) charts had an appropriate clinical response.
-3 of 5 (60%) of the patients were advised of laboratory results.

FINDINGS:
-40% were routine labs and had a report back and acknowledged within seven days.
-50% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment.
-60% of the patients advised of laboratory results.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-67% of routine labs did not have a report back and acknowledged within seven days. No time urgency noted on labs.
-10% of charts with labs did not have an appropriate clinical response, a report back within 24 hours, clinical acknowledgment, and patients advised of laboratory results.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy D-05 (Important) "Hospital and Specialty Care" is compliant with PBNDS 2008.

Ten charts were available for the review using the IHSC Quality of Care Tool.

-4 of 10 (40%) had a documented time urgency included on the order for specialty care or diagnostic services.
-5 of 9 (56%) charts demonstrated that the appointment was accomplished within 45 days of the order. An opthalmology appointment was completed over 50 days after it was ordered. There was no consistency in the completion of the ordered EKGs; some were not done at all and others were completed between nine and over 45 days after the order was entered.
-3 of 4 (75%) detainees were re-evaluated for deterioration.
-8 of 8 (100%) of charts reflect the facility clinician acknowledgment of the specialist's report in the medical record within seven days of the date the service was performed.

FINDINGS:
-60% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.
-44% of charts demonstrated that the appointment was accomplished within 45 days of the order.
-25% of detainees were not re-evaluated for deterioration.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-During the current site visit, the evidence of the QA monitoring was not available.
-75% of charts did not have a documented time urgency included on the order for specialty care or diagnostic services.

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-One detainee did not receive a specialty appointment within ordered time frame.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake process. Detainees who screen positive are referred to a mental health provider (LPC) and are generally seen on the next day.

Ten records were reviewed using the IHSC Quality of Care Tool.
-10 of 10 (100%) had a clinical assessment, treatment and follow-up plan documented.
-10 of 10 (100%) patients reviewed had a treatment plan updated at a minimum of every 90 days.

PREVIOUS FINDINGS (August 2017):
-One of the detainees did not receive a documented mental health clinical assessment, treatment and follow-up plan.

Treatment of Disability

POLICIES REVIEWED: POLICY G-02 (Essential) "Patients with Special Health Needs";Policy G-10 "Aids to Impairment" is compliant with PBNDS 2008.

All dorms in RGDC are wheelchair accessible. The facility has a TTY phone available. The facility also has walkers, wheelchairs and canes available.

At the time of this audit, there was only two detainees with documented disabilities. These records were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-0 of 2 (0%) had the disability prominently displayed in the medical file. There was a detainee deaf/mute detainee and a detainee who was an amputee; the disability was documented in the record, but not prominently displayed. HSA reported that the physician normally noted the disability on the problem list during the first visit.
-2 of 2 (100%) detainees were assessed for assistance with activities of daily living (ADL) upon identification of disability and appropriate accommodation orders were entered.

FINDINGS:
-Two disabilities was not prominently displayed in the medical file.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-One disability was not prominently displayed in the medical file.

Complaints and Grievances

POLICIES REVIEWED: Policy A-11 (Essential) "Grievance Mechanism for Health Complaints" is complaint with PBNDS 2008.

Per HSA, all dorms have access to grievance forms and a drop box labeled for this purpose. The grievance officers picks them up and reviews them daily. All medical grievances are placed in the HSA's mailbox. The HSA is then responsible for answering all medical grievances.

During the site visit, FMC reviewed the Detainee Grievance Log using the IHSC Quality of Care Audit Tool. The review of the log does not show any possible barriers to care or repetitive concerns that could affect clinical care. There were no medical grievances submitted over the past three months.

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PREVIOUS FINDINGS (August 2017):
-At the time of this audit, there were no grievances.

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Diabetes

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is complaint with PBNDS 2008.

Five diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose; no other charts were available for reasons specified earlier in the report.

-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of diabetes.

-3 of 5 (60%) had a blood sugar measured at intake. HSA noted that these intakes were completed by a new nurse.
-5 of 5 (100%) were seen for chronic care by a medical provider within 14 days.
-0 of 5 (0%) had a baseline HgA1C performed within the first 30 days. One chart's documentation showed evidence of a diabetic detainee being unresponsive and a code being called in the facility. His blood sugar was over 500. The physician ordered STAT labs that were never drawn; there was other labs that the physician ordered on the initial visit that was never drawn by the nursing staff and was not entered in MedPAR.
-0 of 5 (0%) had lipids measured within one year.
-5 of 5 (100%) were prescribed aspirin as clinically indicated.
-0 of 5 (0%) charts demonstrated a degree of control (goal GgbA1C<8.0) documented.
-0 of 5 (0%) charts demonstrated a strategy to attain diabetes control documented in HgbA3C above the goal.

FINDINGS:
-Two diabetic detainees did not have their blood sugar taken during the intake process.
-The physician ordered labs on all of the diabetic detainees. The nursing staff did not draw labs (HgAIC or lipids) per the doctor's orders.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-One diabetic detainee did not have his blood sugar taken during the intake process.

Human Immunodeficiency Virus (HIV)

At the time of this audit, RGDC had one ICE detainees documented as having HIV and because only active charts are maintained on site, there was only one file to review. For this reason, the IHSC Quality of Care Audit Tool designed for this purpose was used for one chart.

-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of HIV.

-The HIV status was identified by patient interview.
-The CD4+ and viral load was not completed within 14 days.
-Detainee was not seen by HIV or ID Specialist within 30 days.
-Antiviral treatment was considered and documented.
-Chest x-ray was not completed in 72 hours; it was completed eight days after intake.

PREVIOUS FINDINGS (August 2017): No findings.

Hypertension

Ten charts of hypertensive detainees were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.

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-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of hypertension.
-10 of 10 (100%) had a documented blood pressure on the medical intake.
-10 of 10 (100%) detainees were seen by a medical provider within the first 14 days at the facility.
-9 of 10 (90%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90 that included a treatment plan initiated within 14 days of identifications. On several charts, the nurse did not document if the hypertensive patient was symptomatic. One chart showed that blood pressure checks were not completed as ordered.
-2 of 10 (20%) cases, it appeared that a chronic disease guideline for HTN, which included obtaining baseline lab work, was followed. The physician ordered the labs according to the chronic disease guideline, but the nurses did not follow the doctor's orders. There was no consistency in the completion of lab orders. Some labs were not completed and other labs were completed up to 35 days after it was ordered. EKGs on HTN detainees were not completed in a timely manner; see findings in the diagnostic section of the report. Only one chart showed that the blood pressure checks were not ordered by the physician.

FINDINGS:
-One chart revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90 that did not include includ a treatment plan initiated within 14 days of identifications.
-80% of cases, the nursing staff did not follow the doctor's orders to aid with following the chronic care guidelines for HTN patients.
-HSA presented proof of training completed with medical staff on February 28, 2018. Q&A Nurse is currently following this area under a Corrective Action plan until 12 May 2018.

PREVIOUS FINDINGS (August 2017):
-There was no consistency with blood pressure monitoring on detainees who had a history of HTN and presented with a high systolic blood pressure during intake.
-There was one chart that included a blood pressure check flowsheet on a detainee who was hypertensive, but the blood pressures where consistently high and there was no treatment plan identified for this patient (i.e. no change of medication). This chart had no time urgency noted on labs and there was no chronic care appointments or notes present in the chart for this patient.
-One patient received continuity of care with medications on intake, but labs were ordered over 45 days later.

Asthma

Five charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of asthma.
-5 of 5 (100%) were seen for chronic care by a medical provider within 14 days of illness identification.
-5 of 5 (100%) had a peak flow measurement completed during the initial physical exam.
-5 of 5 (100%) had a peak flow completed at the chronic care visit or within the last three months.
-5 of 5 (100%) showed disease management consistent with BOP clinical practice guidelines.

PREVIOUS FINDINGS (August 2017):
-At the time of this audit, the HSA was not able to show evidence of QA monitoring or staff education as indicated in the December 2016 UCAP.
-One detainee did not have a peak flow measurement completed during the initial physical exam.

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Seizure Disorder

At the time of this audit, RGDC had no ICE detainees documented as having seizures and because only active charts are maintained on site, there were no files to review. For this reason, the IHSC Quality of Care Audit Tool designed for this purpose was not used.

-RGDC uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of seizures.

PREVIOUS FINDINGS (August 2017):
-The HSA was unable to show evidence that QA monitoring or staff education was done as indicated in December 2016 UCAP.
-The chart available for review showed that serum drug levels were not obtained on the detainee who was taking anti-convulsant medications. There were documented refusals in the chart for the medication and the patient was later admitted to the ER where serum levels were taken at that time.
-This detainee did not have a documented treatment plan.

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Recommendations

(b)(5)

Facility Actions

The HSA, Q&A Nurse, (b)(6); (b)(7)(C) CCS, and the Warden were notified of all findings/ deficiencies during the close-out interview. HSA stated that she had a plan to have the new CMA to aid with MedPARs, the new DON and some additional staff. HSA and Q&A Nurse began discussion of processes to put in place for the labs, EKGs and other diagnostic tests prior to FMC leaving the site visit. HSA and QA nurse implemented plan to have chest x-ray and consult for ID specialist done upon intake for HIV detainees. HSA reported changing the process and emailed the nurses and instructed them to write disabilities on the problem list during intake. Sent a close out summary of findings, recommendation and HSA plans to Laredo AFOD, CORs, SNA DFOD and SNA FOD.

Additional Comments

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End of Report

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Phone Number: +1 (210) 283- (b)(6); (b)(7)(C)	Date Prepared: 03/27/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 507 (b)(6); (b)(7)(C)	Date Reviewed:
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (202) 507- (b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/19/2018

Recommendations:
(b)(5)

AMERICAN OVERSIGHT

ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (Follow Up to FMC Site Visit: December 2019)

Facility Name: Rio Grande Detention Center	**Address (Full): 1001 San Rio Blvd.**	
Date FMC Initiated Request for UCAP: 2/3/2020	**City: Laredo**	**County: Webb**
Complete and Return to IHSC FMC No Later Than: 30 days	**State: TX**	**Zip Code: 78046**
Name of Facility Staff Assigned to Develop / Oversee Corrective Action Plan: (b)(5) **HSA**		
Date CAP Submitted by Facility: 3/9/2020		
IHSC Approver – Print Name (First, Last): (b)(5)	**Title of IHSC Approver: Regional FMC**	
Date CAP Approved by IHSC: 3/11/2020		
Signature and Date IHSC Closed Out CAP: 3/11/2020-fo (b)(5) **te visit, ODO on site 10-13MAR20**		

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Reviews) Rio Grande Detention Center (SNA AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
All new arrivals shall receive TB screening within 12 hours of intake and using methods in accordance with CDC guidelines for non-minimal risk detention facilities (C.	The health services administrator (HSA) instructed the nurses on January 15, 2020, to review the purified protein derivative (PPD) log every shift to ensure the results of skin tests have been read. The charge nurses were also instructed to fax the detainee name and A-number to mobile imaging and lab services for scheduling a chest X-	The health records for 30 new arrivals were reviewed from the weeks of January 23, 2020, February 11, 2020, and February 21, 2020, and all new arrivals received TB screening within 12 hours of arrival. Next, a review of the PPD log documented the skin tests administered for new arrivals were read within 48 hours. Detainees with a reading 10mm and above were ordered a chest x-ray within 72 hours and were medically cleared to be placed in general population if they were TB symptom free. There were 15 inmates	3/11/2020-f/u next FMC site visit approx. 6 months

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Communicable Disease and Infection Control)	ray when a detainee had a skin test reading of 10 millimeters or greater. To verify compliance with the standard requirements. The HSA, or designee, will review 30 intake screenings for the next 30 days to confirm each detainee receives TB screening within 12 hours of arrival.	with 10mm or greater and referred for chest x-rays. When detainees' chest x-rays read positive for the disease, they are placed in the negative pressure room and cultures are collected. During this period, 1 inmate was placed in the negative pressure room and treated for active tuberculosis in accordance with community standards of care.	
ICE Uniform Corrective Action Plan (FMC Reviews) **Rio Grande Detention Center (SNA AOR)**			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within 14 days of the detainee's arrival unless	The HSA tasked the data entry clerk with generating a daily list of detainees who are due for their initial and annual comprehensive health appraisals. The HSA is using this system to timely schedule detainees for their initial and annual comprehensive health appraisals. The HSA or designee will audit 30 charts over a period of 3 weeks to	Thirty of 30 charts audited from the weeks of January 27, 2020, February 3, 2020, and February 12, 2020, were compliant with completing timely comprehensive health appraisals. Next, the HSA reviewed the lists of detainees generated by the data entry clerk for February 4, 2020, and February 11, 2020, and found all detainees were current with their comprehensive health appraisals. The HSA will continue to review the detainee list on a weekly basis to ensure the timely completions of comprehensive health appraisals. The HSA will address deficiencies	3/11/2020-f/u next FMC site visit approx. 6 months

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more immediate attention is required due to an acute or identifiable chronic condition, in accordance with the most recent ACA Adult Local Detention Facility standards for Health Appraisals. (J. Health Appraisals).	ensure compliance with the standard.	through providing refresher training with the providers.	
Detainees will have access to a continuum of health care services, including prevention, health education, diagnosis, and treatment. (Medical Care)	The health services subcontractor will continue to recruit qualified staff as department vacancies occur. Health care coverage is provided 24 hours per day, 7 days per week by licensed nursing staff. The medical director, dentist, and mental health providers are accessible 5-days per week.	(b)(7)(E)	3/11/2020-f/u next FMC site visit approx. 6 months

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Detainees with chronic conditions will receive care and treatment for conditions where non-treatment would result in negative outcomes or permanent disability as determined by the clinical medical authority. (Medical Care)	An independent, licensed medical professional was on site January 2020 conducting monitoring reviews of the chronic care clinics and health records of detainees enrolled in the clinics. In addition, he conducted the medical director's peer review and provided guidance based upon the Federal Bureau of Prisons clinical practice guidelines. Next, the HSA conducted an assessment of the workflow practices with the intent to improve the overall management of the chronic care clinics. As a result of this assignment, the HSA has assigned the doctor of nursing practice (DNP) to work full time with the medical director in the chronic care clinics. The HSA also directed clinical staff on February 18, 2020, to conduct a full review of health records for detainees enrolled in the diabetic, hypertension, HIV	As of this writing, the facility's medical director is conducting chronic care clinics 5 days per week and the doctor of nursing practice (DNP) is conducting chronic clinics 4 days per week according to applicable industry standards, e.g., BOP clinical practice guidelines, and Wellpath policies. Next, eighteen chart audits conducted by clinical staff, as of this writing, reflected 100% compliance with community standards of care and clinical practice guidelines.	3/11/2020-f/u next FMC site visit approx. 6 months

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	and seizure clinics to ensure compliance with the chronic care clinic requirements.		
The administrative health authority shall implement an intra-organizational, external peer review program for all independently licensed medical professional. Reviews are conducted at least every two years. (Health Care Internal Review and Quality Assurance)	The health services subcontractor deployed an independent, licensed medical professional to conduct the required peer reviews. The dates on which the peer reviews were completed follows: • Mental health provider – June 6, 2019 • Medical director – June 10, 2019 • Dentist – February 5, 2020 The remaining dentist is not due for his peer review until April 30, 2020.	As of February 11, 2020, all peer reviews for the providers due at this time have been completed.	3/11/2020-f/u next FMC site visit approx. 6 months
Health care services will be administered by a sufficient number	(b)(7)(E)	(b)(7)(E)	3/11/2020-f/u next FMC site visit approx. 6 months

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of appropriately trained and qualified personnel (see staffing section)	(b)(7)(E)	(b)(7)(E)	

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001893

ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (Follow Up to FMC Site Visit: November 2019)

Facility Name: Brooks County Detention Center	**Address (Full):** 9001 County Rd 201	
Date FMC Initiated Request for UCAP: 2/3/2020	**City: Falfurrias**	**County: Brooks**
Complete and Return to IHSC FMC No Later Than: 30 days	**State: TX**	**Zip Code:** 78355
Name of Facility Staff Assigned to Develop / Oversee Corrective Action (b)(6); (b)(7)(C) **HSA**		
Date CAP Submitted by Facility: 3/20/2020		
IHSC Approver – Print Name (First, Last): (b)(6); (b)(7)(C)	**Title of IHSC Approver: Regional Field Medical Coordinator**	
Date CAP Approved by IHSC: 3/25/2020		
Signature and Date IHSC Closed Out CAP: March 25, 2020	(b)(6); (b)(7)(C)	

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Reviews) Brooks County Detention Center (SNA AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
An initial dental screening should be performed within 14 days of the detainee's arrival. If no on-site dentist is available, the initial dental screening may be performed by a physician, physician's assistant or nurse practitioner. Finding: RNs perform dental screens NDS Medical Care. III. E. Dental Treatment.	(b)(7)(E)	05-20-2020	3/25/2020-follow up next site visit/current practice in alignment with higher standard

AMERICAN OVERSIGHT

The health care provider of each facility will conduct a health appraisal and physical examination on each detainee within 14 days of arrival at the facility. Finding: Finding-11 of 18 (61%) of Health Assessments were not conducted within 14 days (A#s (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) NDS D. Medical Screenings.	(b)(7)(E)	05-06-2020	3/25/2020-no detainees at this facility currently/will follow up at next FMC site visit

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 02/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? BOP

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within the past 3 months? Were lipids measured
4	within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated? *
7	Was degree of control (goal HgbA1C <8.0) documented?
8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	NO	YES	N/A	N/A	N/A	N/A	N/A	N/A
2		YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3		YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4		NO	NO	NO	N/A	N/A	N/A	N/A	N/A
5		YES	YES	NO	N/A	N/A	N/A	N/A	N/A
6		NO	YES	N/A	N/A	N/A	N/A	N/A	N/A
7		YES	N/A	NO	N/A	N/A	N/A	N/A	N/A
8		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Total	4 /7 57 %	3 / 4 75 %	0 / 3 0 %	0 / 0 0 %	0 /0 0 %	0 0 0%	0 / 0 0 %	0 0 0 %

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 02/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1 Was there a documented time urgency included on the order for specialty care or diagnostic services?
2 Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3 Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4 Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	NO CHARTS	Other	NO	N/A	N/A	N/A
2	REVIEWED	Other	NO	N/A	N/A	N/A
3		Other	NO	N/A	N/A	N/A
4		Other	NO	N/A	N/A	N/A
5		Other	NO	N/A	N/A	N/A
6		Other	NO	N/A	N/A	N/A
7		Other	NO	N/A	N/A	N/A
8		Other	NO	N/A	N/A	N/A
9		Other	NO	N/A	N/A	N/A
10		Other	NO	N/A	N/A	N/A
		Total	/ %	/ %	/ %	/ %

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item #	Measure
1	Is there an outbound progress note?
2	*Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3	Is there discharge documentation from the hospital or ED in the chart?
4	Is there an inbound assessment?
5	Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	kidney stone	YES	NO	YES	YES	YES
2			NO	NO	NO	NA	NA
3			NO	NO	NO	NA	NA
4			NO	NO	NO	NA	NA
5			NO	NO	NO	NA	NA
6			NO	NO	NO	NA	NA
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	YES	NO	NA	NA
			1 / 1 100 %	0 / 1 0 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised September 2016

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	NO
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	NA	NA	NA	NO
6		YES	YES	NA	YES	YES
7		YES	NA	NA	YES	YES
8		YES	YES	NA	NA	NO
9		YES	NA	NA	YES	NO
10		YES	NA	NA	YES	NO
	Total	/ %	/ %	/ %	/ %	/ %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?
2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4 Is there timely follow-up for significant findings of acute and chronic conditions?*
5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	NA	NA	YES	NO
9		YES	YES	NA	YES	NO
10		YES	YES	NA	NA	NO
	Total	20 / 20 100 %	15 / 15 100 %	0 / 0 NA %	17 / 17 100 %	12 / 20 60 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?Was
3 patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	NO CHARTS	Recent Lab	NA	NA	NA	NA	NO
2	REVIEWED	Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		/ %	/ %	/ %	/ %	/ %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001902

CHRONIC DISEASE – HYPERTENSION

DATE 02/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? BOP

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	N/A	YES
4		YES	YES	N/A	NO
5		YES	YES	N/A	YES
6		YES	YES	YES	NO
7		YES	NO	N/A	YES
8		YES	YES	YES	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	10 / 10 100 %	9 / 10 90 %	4 / 4 100 %	8 / 10 80 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	NO	YES	YES	NO	NO
2		NO	YES	YES	YES	NO
3		NO	YES	YES	NO	NO
4		NO	YES	YES	YES	YES
5		NO	YES	YES	YES	NO
6		NA	NO	NO	NO	NA
7		NA	NO	NO	NO	NA
8		NA	NO	NO	NO	NA
9		NA	NO	NO	NO	NA
10		NA	NO	NO	NO	NA
	Total	0 / 5 0 %	5 / 5 100 %	5 / 5 100 %	3 / 5 60 %	1 / 5 20 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001904

MEDICATION ADMINISTRATION PRACTICES

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 0
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 1
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 75%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		7	YES	YES
3		0	NA	NA
4		0	NA	NA
5		0	NA	NA
6		0	NA	NA
7		0	NA	NA
8		0	NA	NA
9		0	NA	NA
10		0	NA	NA
	Total		1 /1 100%	1 /1 100%

Reviewed September 2016

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record: N/A

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	NA	Compliant	NA	Compliant	Compliant
Flowsheets	Compliant	Compliant	NA	Compliant	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	Compliant	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	Compliant	Compliant	NA	NA	Compliant
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	NA	NA	NA	NA
Timely filing, within 72 hours	Compliant	Compliant	Compliant	NA	NA
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

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MEDICAL RECORDKEEPING PRACTICES

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record: N/A

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	NA	NA	NA	NA	NA
Lab and diagnostic reports[6]	NA	NA	NA	NA	NA
Flowsheets	Compliant	NA	NA	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	Compliant	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	Compliant	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	NA	NA	NA	NA	Compliant
Timely filing, within 72 hours	Compliant	Compliant	NA	NA	NA
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

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MENTAL HEALTH SCREEN

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	4 / 4 100 %

KEY: NA = Not Applicable

Revised September 2016

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	NA
3		YES	NA
4		YES	NA
5		YES	NA
6		YES	NA
7		YES	NA
8		YES	NA
9		NO	NA
10		NO	NA
	Total	8 / 8 100 %	1 / 1 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

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INTAKE EVALUATION: PREGNANT WOMEN

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	NO CHARTS	NA	NA	NA	NA	NO	NO
2	REVIEWED	NA	NA	NA	NA	NO	NO
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	/ %	/ %	/ %	/ %	/ %	/ %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

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CHRONIC DISEASE – SEIZURE DISORDER

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? BOP

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	NO	NO	NO	YES	YES
2		NA	NA	NA	NA	YES
3		NA	NA	NA	NA	YES
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	0 / 1 0 %	0 / 1 0 %	0 / 1 0 %	1 / 1 100 %	3 / 3 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

Revised September 2016

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SUICIDE SCREENING

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 5

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ☑ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ☑ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	At least q 15 min	YES	NO
2		NO	NO	At least q 15 min	NO	NO
3		NO	NO	At least q 15 min	NO	NO
4		NO	NO	At least q 15 min	NO	NO
5		NO	NO	At least q 15 min	NO	NO
6		NO	NO	At least q 15 min	NO	NO
7		NO	NO	At least q 15 min	NO	NO
8		NO	NO	At least q 15 min	NO	NO
9		NO	NO	At least q 15 min	NO	NO
10		NO	NO	At least q 15 min	NO	NO
	Total	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	0 / 1 0 %

KEY: NA= not applicable

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TREATMENT OF DISABILITY

DATE: 2/22/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Rio Grande Detention Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	0 / 0 NA %

KEY: NA = not applicable

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URGENT CARE (SICK CALL)

DATE 02/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	gastritis	YES	YES	YES	YES	YES
2		cold s/sx	NO	YES	YES	N/A	N/A
3		cold s/sx	NO	YES	YES	YES	YES
4		cold s/sx	NO	YES	YES	N/A	N/A
5		headache	NO	YES	YES	N/A	N/A
6		sore throat	YES	YES	YES	N/A	N/A
7		sore throat	YES	YES	YES	N/A	N/A
8		foot pain	YES	YES	YES	N/A	N/A
9		foot fungus	NO	YES	YES	N/A	N/A
10		cold s/sx	YES	YES	YES	N/A	N/A
		Total	5 / 10 50 %	10 / 10 100 %	10 / 10 100 %	2 / 2 100 %	2 / 2 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
03/21/2017	07/18/2016	Rio Grande Detention Facility (RGDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	SNA AOR

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
621	621	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)	Phone Number: +1 (956) 718- (b)(6); (b)(7)(C)
Address: 1001 San Rio Blvd. Laredo, TX 78046	Address: 1001 San Rio Blvd. Laredo, TX 78046

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 2008 deficiencies:
1) Several health appraisals were performed greater than 14 days after arrival to the facility (Medical Care)(V)(J).

2) Medical grievances are not tracked and logged in a Detainee Grievance Log (Grievance System)(V)(E).

PREVIOUS FINDINGS (July 2016): PBNDS 2008 deficiencies
1) HIV positive detainees did not routinely receive a CXR to rule out TB (Medical Care)(V)(C)
CURRENT FINDING: There were no HIV charts to review during this site visit.

2) There were several long-standing staff vacancies which included key leadership positions (Medical Care)(II)(29).
CURRENT FINDING: There are currently no longstanding vacancies and all leadership positions have been filled.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
40	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No PBNDS 2008 deficiencies or previous deficiencies during July 2016 site visit.

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POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is compliant with PBNDS 2008.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No PBNDS 2008 deficiencies or previous deficiencies during July 2016 site visit.

POLICIES REVIEWED: Policy I-05 (Important) "Informed Consent and Right to Refuse" is compliant with PBNDS 2008.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
1	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No PBNDS 2008 deficiencies or previous deficiencies during July 2016 site visit.

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is compliant with PBNDS 2008.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No PBNDS 2008 deficiencies or previous deficiencies during July 2016 site visit.

POLICIES REVIEWED: Policy A-10 (Essential) "Procedure in the Event of a Patient Death"; Policy G-11 (Important) "Care of the Terminally Ill"; Policy I-04 (Important) "End-of-Life Decision Making"

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on February 21-23, 2017. The audit consisted of a review of over 65 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees. Older medical charts were not accessible because they are not maintained on-site at the facility. At the current time, the facility moves any inactive ICE charts to another nearby GEO facility on a weekly basis due to a lack of on-site storage space.

--FACILITY DATA:
Rio Grande Detention Center (RGDC) is a non-dedicated contracted detention facility located in Laredo, Texas. It is owned and operated by GEO Corporation. The facility houses a combination of US Marshal (USM) male and female prisoners and male ICE detainees. The majority of ICE detainees are citizens of El Salvador pending deportation. The facility consists of eight housing units, two of which are dedicated to ICE detainees.

--POPULATION CHARACTERISTICS:
-Total Inmate Capacity - 1900 (672 ICE detainees and 1228 US Marshall prisoners)
-Current total population - 1621
 --ICE - 621
 --USM - 1000
-Average Daily ICE Population for 2016 - 478
-The average ICE detainee stay is 11.7 days

--ACCREDITATIONS/INSPECTIONS:
-PBNDS 2008 (Nakamoto) - March 2016
-NCCHC - last completed in September 2013/NCCHC is scheduled to visit May 22-24, 2017
-ACA - April 2016

MEDICAL CLINIC/INFIRMARY:
-The medical clinic is spacious with a large centralized nurse's station. There are three exam rooms, a dental suite, a dental procedure room with panoramic x-ray, a locked pharmacy, a locked medical records room, and an urgent care suite.
-The urgent care suite has an emergency bag, a gurney, 2 AEDs, tank oxygen, portable suction,

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and an electrocardiogram. Emergency equipment is checked daily by the nursing staff.
-Connected to the medical clinic is a 15 bed infirmary. There are two negative pressure rooms and four mental health rooms with cameras.
-There are 2 suicide observation rooms located in the medical infirmary. The rooms have been modified to accommodate suicidal detainees and all potential harmful objects have been removed.

--MEDICAL STAFFING:

(b)(7)(E)

OTHER SUPPLEMENTAL INFO:
-All (100%) staff credential folders were reviewed. All folders were found to be in good order and well organized. All had a current Basic Life Support (BLS) license and all credentials were current and from the State of Texas.
-The RGDC Policy and Procedure Manual was reviewed. All policies reviewed were found to be consistent with PBNDS 2008 standards. The policies and procedures were last reviewed in December 2016.
-A training folder is maintained on all medical staff. Medical staff receive appropriate training for their position and have competencies documented annually. Staff also receives annual training on several topics including suicide prevention and intervention, hunger strikes, and PREA. Training folders were found to be well organized and up to date.

Deficiencies for Areas Evaluated

--PBNDS 2008 DEFICIENCIES:
-60% of health appraisals reviewed were performed greater than 14 days after arrival.
-Medical grievances are not logged and tracked.

--QUALITY OF CARE ISSUES

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-50% of sick call encounters reviewed were seen greater than 72 hours from the date of triage.
-40% of the lab work reviewed by the FMC did not have an appropriate clinical response documented.
-80% of charts did not show documentation that the detainee was notified of lab results.
-Intake blood sugars were not consistently recorded on detainees claiming to have diabetes.
-Several detainees received delayed chronic care (greater than 14 days from arrival).
-Baseline HgA1C lab work is not being done within 30 days of arrival on diabetic detainees.
-Two hypertension charts reviewed were not seen for chronic care and care was not consistent with a clinical practice guideline. Lab work, EKG, blood pressure monitoring were not ordered.
-The neurological history completed on a seizure patient was inadequate. (REPEAT FINDING)
-A serum drug level was not ordered on a detainee taking anti-convulsant medication.

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Suicide Screening

POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is compliant with PBNDS 2008.

RGDC performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.

In the past six months there have been five detainees on suicide watch. One chart was reviewed using the IHSC Quality of Care Audit Tool designed for this purpose as other five were already moved to off-site location.
-1 of 1 (100%) suicidal patient was evaluated by the physician within 24 hours of identification.
-1 of 1 (100%) was evaluated by a qualified mental health professional every day during the work week (M-F) and by a nurse on weekend days.
-During the entirety of the suicide watch the patient was monitored continuously by a detention officer who documented every 15 minutes.
-In the one chart reviewed, there is no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

PREVIOUS FINDINGS (July 2016): No findings noted.

Health Assessment

POLICIES REVIEWED: Policy E-04 (Essential) "Initial Health Assessment" is compliant with ICE PBNDS 2008.

Twenty charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-15 of 15 (100%) had a PPD placed during the initial intake screening and was read within 48-72 hours.
-17 of 17 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-12 of 20 (60%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, all health appraisals are completed by either the NP or the physician. Generally the NP does all of the healthy physicals and the physician sees those with chronic medical conditions.

PREVIOUS FINDINGS (July 2016): No findings noted.

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy E-07 (Essential) "Non-Emergency Health Care Requests and Services" is compliant with PBNDS 2008.

According to the HSA, the sick call process is initiated by a detainee filling out a paper sick call request. Slips are picked up daily and triaged by the nursing staff. Non-urgent requests are seen by nurses who use clinical protocols and document sick call encounters on standard forms called problem-oriented records, which are available for a large number of medical complaints. Per RGDC policy, all oral or written requests for health care will be triaged within 24 hours by a qualified health care professional. When indicated, the patient will be seen by a qualified health care professional at the next available sick call or clinician's clinic, usually within 24 hours (or up to 72 hours on weekends or holidays).

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool used to evaluate this area.
-5 of 10 (50%) had a timely and appropriate evaluation by nursing staff (seen within 72 hours).
-10 of 10 (100%) encounters demonstrated that care was delivered within the scope of the

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nurse's license.
-10 of 10 (100%) of sick call encounters had vital signs documented during the nurse's assessment.
-2 of 2 (100%) had a nursing referral to a medical provider within 24 hours when appropriate.
-2 of 2 (100%) referred to a medical provider had the assessment and plan documented within the note.

According to the HSA, the facility averages around 100 sick call requests daily. On most days, two nurses are assigned to completing sick call. In addition to completing sick call encounters, the same nurses are also responsible for medication pass and completing any provider ordered treatments or procedures (blood pressure checks, blood sugar checks, PPD reads, and wound care).

PREVIOUS FINDINGS (July 2016): No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

POLICIES REVIEWED: Policy E-08 (Essential) "Emergency Services" is compliant with PBNDS 2008.

In the past six months, 16 detainees have been sent to an emergency department. There was only one chart available for review during this audit. This chart was reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-1 of 1 (100%) had an outbound progress note.
-0 of 1 (100%) showed evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-1 of 1 (100%)had discharge documentation from the hospital and an inbound assessment. There was no evidence to suggest that earlier intervention could have prevented deterioration to the point of needing outside emergency care. In the one chart reviewed, the hospital's recommendations were acknowledged and carried out.

PREVIOUS FINDING (July 2016): Complete hospital records were not found in the charts of detainees who had been sent to the hospital. A UCAP was submitted to the FMC in December 2016 which indicated that RGDC staff would receive training on this subject and that monitoring of compliance would be done through their Quality Assurance (QA) program.
During this site visit, hospital records were found within the one chart reviewed. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

Medication Administration Practices

POLICIES REVIEWED: Policy D-01 (Essential) "Pharmaceutical Operations" and Policy D-02 (Essential) "Medication Services" are compliant with PBNDS 2008.

RGDC contracts with Correct RX for pharmaceutical services. Orders are placed on a daily basis and as needed. Medication ordered prior to 3 PM are received the next day.

Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-RGDC policy specifies that a patient should be referred to the responsible physician after three refusals of any medication. Policy also indicates that when certain high risk medications (i.e., antiepileptics, antibiotics, anticoagulants, antihypertensives, anti-retrovirals/HIV, cardiac medications, hypoglycemic medications, pulmonary medications, or psychotropic medications) are refused for 3 or more doses that a mental health referral also be completed.
-10% of the MARs reviewed contained blanks, consecutive refusals, or no shows. In every case a refusal form was completed.
-The only MARs found pending to be filed were from the previous month.
-Approximately 75% of patients are on self-administered medication ordered by a provider.
-Over the Counter (OTC) medications are provided by both medical and can be purchased at the commissary.

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-Only one of the MARs reviewed had refusals documented and none contained no-shows. A refusal form was completed on all refusals.

PREVIOUS FINDING (July 2016): MARs were not filed into the appropriate medical record upon discharge from the facility. A UCAP was submitted to the FMC in December 2016 which indicated that staff training would be done and TDY staff would be used to catch up backlog. The UCAP also specified that monitoring of compliance would be done through their Quality Assurance (QA) program.
At this site visit it was noted that the vast majority of records reviewed were active charts; however, all inactive charts reviewed contained a MAR. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

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Continuity of Medication

POLICIES REVIEWED: Policy E-12 (Essential) "Continuity of Care During Incarceration" is compliant with PBNDS 2008.

When a detainee arrives to the facility with chronic medications the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) charts showed that medications were ordered in less than 24 hours from completion of the intake.
-In 10 of 10 (100%) cases, the period of time from order to first dose was less than 24 hours.

PREVIOUS FINDINGS (July 2016): No findings noted.

Mental Health Screen

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide.

Four active charts selected from the mental health caseload were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-4 of 4 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (July 2016): No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy H-01 (Essential) "Health Record Format and Contents" is compliant with PBNDS 2008.

All charting at Rio Grande Detention Center is done on paper. Medical records are kept in a locked room to which only medical personnel have access to. At the current time, there are no plans to obtain an electronic medical record.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool. Charts were found to be complete and orderly.

PREVIOUS FINDINGS (July 2016): No findings noted.

Pregnant Women

Rio Grande Detention Facility only houses male ICE detainees.

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Dental Care

POLICIES REVIEWED: Policy E-06 (Essential) "Oral Care" is compliant with PBNDS 2008.

Rio Grande Detention Facility has (b)(7)(E) All detainees receive a dental screening by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request. The dentist evaluates the patient the following working day and decides if treatment is appropriate. The treatment is then scheduled within one week.

Four active charts selected from the sick call log were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-4 of 4 (100%) were screened for symptoms during the intake process.
-4 of 4 (100%) were evaluated by a qualified health professional within 48 hours of the request.
-4 of 4 (100%) dental notes reviewed described findings, diagnosis, treatment, and plans.
-4 of 4 (100%) were scheduled for follow-up treatment as recommended.

PREVIOUS FINDINGS (July 2016): No findings noted.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy D-04 (Important) "Diagnostic Services" is compliant with PBNDS 2008.

Labcorp is contracted to pick up and process the labs collected at the facility. For STAT labs, Laredo Medical Center is utilized.

None of the charts reviewed contained STAT or acute lab work orders; however, five contained completed routine lab work. The IHSC Quality of Care Tool was used to evaluate these records.

-5 of 5 (100%) were routine labs and had a report back and acknowledged within seven days.
-3 of 5 (60%) had an appropriate clinical response. There were two lab reports which contained abnormal labs. In both cases, the medical record did not contain an appropriate clinical response or corresponding notation from the reviewing physician.
-1 of 5 (20%) patient charts reviewed had documentation that the patient was advised of the lab results.

PREVIOUS FINDINGS (July 2016): No findings noted.

CURRENT FINDINGS:
1) 40% of lab work reviewed by the FMC did not have an appropriate clinical response.
2) 80% of charts did not show documentation that the detainee was notified of lab results.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy D-05 (Important) "Hospital and Specialty Care" is compliant with PBNDS 2008.

There were no charts available for review which contained diagnostic services or specialty care during this FMC audit and therefor the IHSC Quality of Care Tool was not used.

PREVIOUS FINDINGS (July 2016): A time urgency was not included in the majority of physician orders for outside referrals. A UCAP was submitted to the FMC in December 2016 which indicated that the CD had received training from the CCS Chief Medical Officer on outside medical referral utilization and processing. The UCAP specified that the time frame for outside medical referrals would be noted as either "Emergent", "Urgent", or "Routine". The UCAP also says that compliance will be monitored through the QA program.

CURRENT FINDINGS: There were no charts available for review. At the time of this audit, the HSA was unable to show evidence that QA monitoring has yet been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake screening. Detainees who screen positive are referred to a mental health provider and are generally seen on the next day.

Eight records out of the active mental health case load were reviewed using the IHSC Quality of Care tool.
-8 of 8 (100%) had a clinical assessment, treatment, and follow-up plan documented.
-1 of 1 (100%) patient reviewed had a treatment plan updated at a minimum of every 90 days.
The other mental health notes reviewed were all initial referrals and new additions to the mental health caseload.

PREVIOUS FINDINGS (July 2016): No findings noted.

Treatment of Disability

POLICIES REVIEWED: Policy G-02 (Essential) "Patients with Special Health Needs"; Policy G-10

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"Aids to Impairment" is compliant with PBNDS 2008.

All dorms at RGDC are wheel chair accessible. The facility has a TTY phone available. The facility also has walkers, wheelchairs, and canes available.

At the time of this audit, there was only one detainee documented to have a disability. This record was reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-1 of 1 (100%) had the disability prominently displayed in the medical file.
-1 of 1 (100%) was assessed for assistance of activities of daily living (ADL) upon identification of disability and appropriate accommodation orders were entered.

PREVIOUS FINDINGS (July 2016): No findings noted.

Complaints and Grievances

POLICIES REVIEWED: Policy A-11 (Essential) "Grievance Mechanism for Health Complaints" is compliant with PBNDS 2008.

According to the GEO grievance officer, all dorms have access to grievance forms and a drop box labeled for this purpose. The grievance officer picks them up and reviews them daily. All medical grievances are placed in the HSA's mailbox. The HSA is then responsible for answering all medical grievances.

PREVIOUS FINDINGS (July 2016): No findings noted.

CURRENT FINDINGS: At the time of this audit, there was not a grievance log maintained within the medical department. This seems to have been an oversight on the part of the new medical contractor, Correct Care Solutions, when they took over management of the medical department in November 2016. The HSA advised that a grievance binder would be immediately created and maintained. She told the FMC that she has had approximately two ICE medical grievances since she arrived in December 2016. The FMC was unable to review these grievances for the reason stated above. RGDC policy A-11 states that all medical grievances will be tracked on CCS form #00046 Grievance Log. The policy also states that a written response with decision and rationale is provided to the detainee within five working days of receipt of the grievance.

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Diabetes

POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is compliant with PBNDS 2008.

Seven diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose.
-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of diabetes.
-4 of 7 (57%) had a blood sugar measured at intake.
-3 of 4 (75%) were seen for chronic care by a medical provider within 14 days. Three others left the facility before being seen for chronic care and prior to day 14. In every case, diabetic medication was either continued or a new order was received via telephone order during the medical intake.
-0 of 3 (0%) had a baseline HgA1C performed within the first 30 days. In every case, the lab was ordered during the initial chronic care appointment, but not drawn by day 30. According to the chronic care nurse, lab work is usually collected just prior to the next scheduled follow-up, which normally is completed 30 days after the initial chronic care visit. In every case lipids were also ordered as part of the baseline work-up for diabetic patients.

PREVIOUS FINDINGS (July 2016): No findings noted.

CURRENT FINDINGS:
1) Intake blood sugars were not consistently recorded on detainees claiming to have diabetes.
2) One diabetic detainee was not seen for chronic care within 14 days.
3) Baseline HgAIC lab work was not done within 30 days of arrival on all diabetic charts reviewed.

Human Immunodeficiency Virus (HIV)

At the time of this audit, RGDC had no ICE detainees documented as having HIV and because only active charts are maintained on site, their were no files to review. For this reason, the IHSC Quality of Care Audit Tool designed for this purpose was not used.
-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of HIV.

PREVIOUS FINDINGS (July 2016):
1) HIV positive detainees did not routinely receive a CXR to rule out TB.
2) HIV lab work was not consistently obtained within the first 14 days at the facility.
3) Antiretroviral medication was not initiated on HIV-positive detainees who arrived without their own medication.
A UCAP was submitted to the FMC in December 2016 which indicated that the medical providers have been provided and educated on HIV management clinical practice guidelines and that compliance will be monitored through the QA program.

CURRENT FINDING: Because there were no charts to review, the FMC was unable to verify that previous practice has changed. The HSA advised that RGDC has not had any HIV detainees since drafting the UCAP. The FMC will continue to follow-up with the HSA.

Hypertension

10 charts of hypertensive patients were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of hypertension.
-10 of 10 (100%) had a documented blood pressure on the medical intake.
-9 of 10 (100%) patients were seen by a medical provider within the first 14 days at the facility.
-4 of 10 (40%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90. In all four (100%) medical records there was

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documentation that the nurse called and received a treatment plan from the provider which included medication and blood pressure monitoring.
-In 8 of 10 (80%) cases, a chronic disease guideline was followed for HTN, which included obtaining baseline lab work, was followed. In the other two case, the patients received a physical exam but not a chronic care workup (i.e., lab work, EKG, etc.).

PREVIOUS FINDINGS (July 2016): No findings noted.

CURRENT FINDINGS:
1) One detainee with hypertension was not seen for chronic care within 14 days.
2) Two hypertension charts reviewed were not seen for chronic care and care was not consistent with a clinical practice guideline. Lab work, EKG, blood pressure monitoring were not ordered.

Asthma

Six charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of asthma.
-2 of 2 (100%) were seen for chronic care by a medical provider within 14 days of illness identification. All others left the facility prior to day 14 and before being seen by a medical provider.
-2 of 2 (100%) had a peak flow measurement completed both during the physical exam and when seen for chronic care.
-2 of 2 (100%) showed disease management consistent with BOP clinical practice guidelines.

PREVIOUS FINDINGS (July 2016): Peak flow measurements were not consistently recorded within the physical exams of asthmatic detainees. A UCAP was submitted to the FMC in December 2016 which indicates that medical providers have been educated on asthma management clinical practice guidelines. The UCAP also says that compliance will be monitored through the QA program.

CURRENT FINDINGS: No findings noted. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.

Seizure Disorder

Three charts of seizure patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-Rio Grande Detention Center uses Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the management of seizures.
-0 of 1 (0%) had an appropriate neurological assessment completed at the initial physical exam. In the one chart reviewed, the only thing that was documented for neurological history was that seizures were secondary to trauma. No further details were documented including type of trauma, frequency of seizures, and last seizure activity. The other two departed the facility prior to day 14 and prior to receiving a physical exam and initial chronic care appointment.
-0 of 1 (0%) were seen for chronic care by a medical provider within 14 days of illness identification. In this case, anticonvulsant medication was continued from intake so he never went without medication; however, the physical exam and initial chronic care appointment occurred greater than 14 days after arrival.
-0 of 1 (0%) had serum drug levels ordered. In this case the detainee was taking Tegretol prior to arrival and when seen by the physician, serum drug levels were not ordered.
-1 of 1 (100%) had an established treatment plan.
-3 of 3 (100%) had orders for a bottom bunk.

PREVIOUS FINDINGS (July 2016): A complete neurological history was not being completed on the majority of seizure patients. A UCAP was submitted to the FMC in December 2016 which indicated that medical providers would be educated on seizure management clinical practice

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guidelines. The UCAP also says that compliance will be monitored through the QA program.

CURRENT FINDINGS:
1) The issue of obtaining a complete neurological history on seizure patients is a repeat finding. At the time of this audit, the HSA was unable to show evidence that QA monitoring or staff education had been done as indicated in the December 2016 UCAP. The FMC will continue to follow-up with the HSA.
2) One seizure patient was not seen for chronic care within 14 days of arrival.
3) A serum drug level was not ordered on a detainee taking anticonvulsant medication.

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Recommendations

(b)(5)

Facility Actions

The HSA and the facility Assistant Warden were notified of all findings/deficiencies during a close-out interview. The Laredo AFOD was given a summary of findings via telephone.

Additional Comments

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End of Report

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Recommendations:

(b)(5)

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CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? BOP

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	NA	NA	NA	NA
2		NA	NA	NA	NA
3		NA	NA	NA	NA
4		NA	NA	NA	NA
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

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COMPLAINTS AND GRIEVANCES

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 2

What percentage of this number were appropriately addressed within 5 working days of receipt? NA %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)		
Denial or refusal of specific request(s) for care		
Delay(s) in care		
Competency/professional skillset of medical staff		
Attitude, demeanor or conduct of staff		
Other		
Total	0	

NCCHC 2014 J-A-06, J-A-11.

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CONTINUITY OF MEDICATION

DATE 02/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 /10 100 %	10 /10 100 %

KEY: NA= not applicable

Revised May 2014

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DHS-ICE-20-0618-A-001936

DENTAL CARE

DATE 2/22/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Rio Grande Detention Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item # Measure

1 Was patient screened for symptoms during the intake process?
2 Was patient evaluated by a qualified health professional within 48 hours of request?
3 Do dental clinical notes describe findings, diagnosis, treatment and plans?
4 Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		NO	NA	NO	NA
6		NO	NA	NO	NA
7		NO	NA	NO	YES
8		NO	NA	NO	NA
9		NO	NA	NO	NA
10		NO	NA	NO	NA
	Total	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

Revised September 2016

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Attachment 2

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CCS
CORRECT CARE SOLUTIONS

MONTHLY GRIEVANCE LOG

Facility RGDC

Month / Year Jan- 4 2017

ICE

(b)(6); (b)(7)(C)

Patient Name	ID#	Date Written	Date Received	Date of Response	Grievance: Co-Pay	Grievance: Staff	Grievance: Access	Grievance: Other	Action Taken or Comments	Outcome
		/17	2/19/17	2/24/17	special diet				denied - Ed. on diet	denied
		11/17	2/19/17	2/24/17	psych med				pt. ed on medication	info
		3/11/17	3/13/17	3/14/17	medication refill				refill ordered, pt ed.	info
		23/17	3/23/17	3/27/17	medication pill pass				pt ed & refill	info
		4/2	4/4/17	4/5/17	sore ribs/x-ray				pt seen 3/31/17	info
		3	4/4/17	4/5/17	renal diet not reed.				verified WITH F/S	info
			4/10/17	4/13/17	dental complaint				refused tx extract.	INFO
		3-17	4-24-17	4-25-17	foot fungus cream				seen 4/24/17 - MED given	info
		2-17	4-24-17	4-25-17	pain med				seen 4/24/17 - MED given	info
		21-	4-24-17	4-25-17	extra pillow				seen 4/8 & 4/14 - Denied	denied
		4-17	4-24-17	4-26-17	medication				no current Rx - F/U MD	denied
		17	5-1-17	5-2-17	tx - wants transfer				tx provided	denied
		4-17	5-15-17	5-17-17	medication specialist				referred to Nephrology	Approved
		3-17	5-3-17	5-4-17	meds for sleep aid				seen by nurse 5/4/17	info
		17	5-3-17	5-3-17	seen for TB meds				seen by FNP 5/2/17	rc-eval
		NONE	6-5-17	6-5-17	ATW				ATW	ATW
		2-17	6-5-17	6-6-17	check vision				seen by FNP	eval/info
		6-17	6-7-17	6-7-17	skin rash				seen by FNP	meds avail
		8-17	6-8-17	6-8-17	sore in lip/mouth				refer to sick call	NOT A GRIEVANCE
		7-17	6-8-17	6-8-17	skin hyperpigmentation				refer to sick call	NOT A GRIEVANCE
		6-8-17	6-13-13	6-13-13	cold				seen @ sick call	not a grievance

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CCS
CORRECT CARE SOLUTIONS

MONTHLY GRIEVANCE LOG

Facility RGDC

Month / Year 2017.

Patient Name	ID#	Date Written	Date Received	Date of Response	Grievance				Action Taken or Comments	Outcome
					Co-Pay	Staff	Access	Other		
(b)(6); (b)(7)(C)		6.10.17	6.13.17	6.14.17	eye prosthesis & secretions				MD sent pt sent to hosp	ER eval
		6.22.17	6.26.17	6.27.17	meds				MD sent pt 7/26	pt seen
		6.30.17	7.3.17	7.3.17	refer to MD				to be seen scheduled	info
		7.4.17	7.6.17	7.6.17	rash				RN seen pt.	meds given
		7.3.17	7.6.17	7.6.17	wants old meds seen by nurse				meds given	meds given
		7.3.17	7.6.17	7.6.17	toe nail problems				seen by MD	referral consult
		7.4.17	7.6.17	7.6.17	dizzy				meds given	seen by RN
		7.6.17	7.7.17	7.7.17	security - wants documents				needs to submit to se	info
		7.9.17	7.10.17	7.10.17	already on sick call line unsigned witness				sick call - meds	meds given
		7.8.17	7.10.17	7.10.17	asked to place sick call wants to see psych				sick call for 4 line	info
		date	7.10.17	7.10.17	wants strong meds.				already on sick call line	info
		7.8.17	7.10.17	7.10.17	constipation wants to see doctor				asked to place sick call	info
		7.11.17	7.13.17	7.13.17	meds not working				scheduled for nurse	re eval.
		7.12.17	7.14.17	7.14.17	has not been seen for a cold				placed on sick call line	eval/info
		7.25.17	7.27.17	7.27.17	ATN (refill for meds)				ATN	ATN
		7.26.17	7.27.17	7.27.17	asking for BP meds				seen by MD & new testing	labs
		7.25.17	7.27.17	7.27.17	asking for glasses				reading glasses she bought @ commissary	
		7.30.17	7.31.17	7.31.17	see MD				made apt 8/1/17	eval.
		8.2.17	8.4.17	8.4.17	sched for psychologist				scheduled for 4 appt	eval
		8.17.17	8.18.18	8.18.18	sched. for sick call for				infection - sched sick call	eval/treat.
		8.25.17	8.28.18	8.28.18	Sched for sick call URI - muscle pain				Sched for sick call	eval/NSC

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CCS
CORRECT CARE SOLUTIONS

MONTHLY GRIEVANCE LOG

Facility RGDC

Month / Year 2017 /

Patient Name	ID#	Date Written	Date Received	Date of Response	Grievance				Action Taken or Comments	Outcome
					Co-Pay	Staff	Access	Other		
(b)(6); (b)(7)(C)		8.25.17	8.28.17	8.28.17	not seen for sick call				was seen 8/27/17	sick call
		8.18.17	8.22.17	8.23.17	headaches				scheduled for MH / MD	eval
		8.20.17	8.21.17	8.23.17	swelling, meds for swelling				scheduled for xray	eval

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Attachment 3

AMERICAN OVERSIGHT

Name: _____

ID# _____

DOB: _____

Neurology/Seizures

Chronic Illness Management Treatment Plan

Date/Time: _____

Allergies: _____

Standard	Date		Date		Date
Annual Flu vaccine		Initial physical		Annual Chest X-ray	
Pneumonia Vaccine		Annual Oral Exam		Annual EKG	

Current Medication	Dosage, Route, Frequency	Current Medication	Dosage, Route, Frequency

Neurological History: When was the last Seizure: _____

When did the Seizures Start: _____ History of Head Trauma: ☐ Yes ☐ No Explain: _____

Manifestation of Seizure: ☐ Generalized ☐ Partial ☐ Other: _____

Medication Use/Compliance: ☐ Poor ☐ Fair ☐ Good

How well are seizures controlled with Medication: ☐ Deteriorating ☐ Stable ☐ Improving

When was last blood level check for seizure medication: _____

Subjective Data:

☐ No Complaints ☐ Fatigue ☐ Cough ☐ Dyspnea on Exertion ☐ Malaise ☐ Anorexia

Objective Data:

Vital Signs Temp _____ Pulse _____ Resp _____ BP _____ Wt. _____ Ht. _____ BMI _____

Pain Scale: 0 No Pain 1 Mild 2 Moderate 3 Severe 4 Very Severe 5 Worse

☐ Peripheral Cyanosis ☐ Digital Clubbing ☐ Pursed lip breathing ☐ Accessory muscles

Physical Findings:	Comments		Comments
Heart		Lungs	
Extremities		Gross Fine Motor Skills Reflexes Arms/Legs	
Ears, nose (nasal polyps), throat, mouth			
Nutritional Status / Diet			
Neuro, Alert/Oriented PERRL			

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Name: _____

ID# _____

Assessment (diagnosis):

Neurology/Seizures _____

_____

Plan: _____

_____

_____

Renew Medications: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days **Inmate Refused:** _____

Return to Clinic: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Labs: ☐ Dilantin Blood Level ☐ Depakote Levels ☐ Other: _____

Diagnostics: ☐ EKG ☐ CXR ☐ Mammogram (every 2 years) ☐ PAP Smears

☐ Fecal occult testing (50 yrs. and older) ☐ Other: _____

Referral: ☐ Dental ☐ Mental Health

Immunizations: ☐ Influenza (Annual) If available during Flu Season * ☐ Pneumococcal (every 5 years)

Patient's Condition*: ☐ Poor ☐ Fair ☐ Good

Patient's Condition*: ☐ Stable ☐ Improving ☐ Deteriorating

Compliance with treatment plan ? ☐ YES ☐ NO

Education: ☐ Diet ☐ Medication ☐ Exercise ☐ Disease Process ☐ Risk Factors and reducers

☐ Signs and symptoms to report ☐ Adaptation to the correctional environment

☐ Medication Compliance ☐ Other: _____

Patient verbalizes understanding? ☐ YES ☐ NO

Interpreted by _____ ☐ Spanish ☐ Other _____ ☐ Not Applicable

_____ _____

Clinician Signature/Title Date

Update 7/2017

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DHS-ICE-20-0618-A-001944

Attachment 4

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CCS
CORRECT CARE SOLUTIONS

PATIENT COMMUNICATION FORM

Patient Name	ID#	DOB	Date
Housing	Facility Rio Grande Detention Center		

Re: **Laboratory /Diagnostic Test Results Notification**

This document serves as notification that your Laboratory / Diagnostic Test results obtained on: Date: were within **Normal** limits. If you have any other questions or healthcare concerns, please submit a Health Services Request Form.

Results: Lab Results -Normal

Este document sirve como notificaccion que sus resultados de Laboratorio o examines de Diagnostico obtanidos en: [Fecha]: estan entre los limites **Normales**. Si usted tiene cualquier otra pregunta o preocupacion por su salud, por favor someta un. formulario de servicios medicos.

Other Information:

Resultados: Laboratorio- Normal

Medical Staff Name or Stamp

Medical Staff Signature

Date / Time

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CCS
CORRECT CARE SOLUTIONS

PATIENT COMMUNICATION FORM

Patient Name	ID#	DOB	Date
Housing	Facility **Rio Grande Detention Center**		

Re: **Laboratory /Diagnostic Test Results Notification**

This document serves as notification that your Laboratory / Diagnostic Test results obtained on: Date: were within **Abnormal** limits. If you have any other questions or healthcare concerns, please submit a Health Services Request Form.

-A Follow-up appointment will be scheduled for Chronic Care Clinic to assess Abnormal Results

Este document sirve como notificaccion que sus resultados de Laboratorio o examines de Diagnostico obtanidos en: [Fecha]: estan entre los limites **Abnormales**. Si usted tiene cualquier otra pregunta o preocupacion por su salud, por favor someta un. formulario de servicios medicos.

-Se programará una cita de seguimiento para la Clínica de Cuidados Crónicos para evaluar los Resultados Anormales

Medical Staff Name or Stamp

Medical Staff Signature

Date / Time

Inmate / Detainee Signature

Date

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DHS-ICE-20-0618-A-001947

Attachment 5

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RECEIVING SCREENING

Last name		Fist name		MI	
ID #		Primary Language:			
DOB		Sex	M	F	
Booking date / time		Medical Screening date/time			
Previous	Yes	No	Location	When	
Vital signs	BP	P	RR	T	Spo2	HT	W
Accu Check	Yes No	Results			
Peak Flow	Yes No	Results			
Do you have any pain?	Yes	No	If **YES**, Explain:		
Pregnant	Yes	No	N/A		

If yes to current meds or psych meds, perform Medication Verification and refer patient for provider examination.

Are you on any medications?	Yes	No	List medications		
Medication verified	Yes	No	(If no, place on MD call line)		
Are you allergic to any meds	Yes	No	List medications		
Sickle Cell	Yes	No			
Other allergies	Food			Yes	No
	Seasonal			Yes	No
	Other			Yes	No
Do you have any medical problems i.e. heart problems/seizures?				Yes	No
Have you recently had any head trauma with loss of conscience in the past 24-48 hours?				Yes	No

Recent hospitalization?	Yes	No				
Have you ever had a positive TB test?	Yes	No	When		Tx/CXR	
Any infectious disease?	Yes	No				

Current symptoms (check any that apply) **any 2 triggers, initiate Tuberculosis Protocol & refer to provider**

Chronic cough		Loss of appetite		Fatigue		Weakness	
Weight loss		Night sweats		Fever		Coughing blood	
Chills		Chest pain		Other			

Have you been diagnosed with any of the following? (check any that apply)

Hepatitis		HIV/AIDS		Tuberculosis		STD	
Other Infectious Diseases							

History of active withdrawal/seizure?	Yes	No	Shakes	Yes	No	Seizures	Yes	No
Describe symptoms								

If yes, refer immediately to provider and initiate Alcohol Withdrawal Assessment Record.

Do you drink alcohol?	Yes	No	Beverage of choice		Quantity		Frequency	

If daily, refer immediately to provider.

When was last drink?		Blood Alcohol Level		Time	
Do you use drugs?	Yes	No	List		

If opiate/benzo, refer immediately to provider.

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Attachment 6

AMERICAN OVERSIGHT

Name: _____

ID#: _____

DOB: _____

Diabetes

Chronic Illness Management Treatment Plan

Date:

Allergies:

Standard	Date	Results	Standard	Date	Results
HgbA1C every 3-6 mos.*			Annual dilated retinal exam*		
FSBS every 3 months Normal range 70-120*			GFR*		
CBC/CMP*			Annual Flu vaccine*		
Creatinine*			Pneumovax as indicated*		
Dipstick urinalysis*			Consider ASA 81mg if no contraindications		
Microalbumin*			Dental Exam*		
BUN*			Physical exam*		
Fasting Lipids*			EKG*		
Foot Exam*			CXR*		
Current Medication	Dosage, Route, Frequency		Current Medication	Dosage, Route, Frequency	

Clinical Guidelines Standard

Subjective Data:

☐ No Complaints ☐ Fatigue ☐ Chest Pain ☐ Arm/Leg Weakness ☐ Arm/Leg Numbness

☐ Headaches ☐ Edema ☐ Smoker ☐ Epigastric Pain ☐ Oral Tobacco Use

☐ Dizziness ☐ Nausea ☐ Vomiting ☐ Shortness of Breath ☐ Change in Urine

☐ Malaise ☐ Polyuria ☐ Diaphoresis ☐ Visual Changes ☐ Visual Disturbances

☐ Constipation ☐ Tremors ☐ Anorexia ☐ Dyspnea on Exertion ☐ Dyspepsia

☐ Confusion ☐ Numbness in Feet ☐ Burning/Stinging in Feet ☐ Other: _____

Objective Data:

Vital Signs Temp _____ Pulse _____ Resp _____ BP _____ O2 % _____ Ht. _____

Wt. _____ BMI: _____ Pain Scale: 0 1 2 3 4 5

Physical Findings:	Comments		Comments
EENT, Mouth, Thyroid		Abdomen	
Neurological		Extremities	
Lungs		Skin	
Heart		Nutritional Status / Diet	
	Fundoscopic eye exam: ☐ vessels normal ☐ disk margins sharp ☐ pupils equal and reactive to light ☐ color normal ☐ other _____		

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Name: _____

ID# _____

Assessment (diagnosis): Diabetes: ☐ Insulin ☐ Non-Insulin

Plan:

Regular Insulin Sliding Scale Subcutaneous

0	to 200	give 0	units
201	to 250	give 3	units
251	to 300	give 5	units
301	to 350	give 8	units
351	to 400	give 10	units

Over 400 > call doctor

Renew Medications: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Inmate Refused:

Return to Clinic: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Labs needed: ☐ CMP* ☐ HgbA1c* ☐ Lipid Profile* ☐ TSH* ☐ UA* ☐ CBC* ☐ Microalbumin*

☐ Creatinine* ☐ BUN* ☐ GFR*

All labs to be drawn within a month of next scheduled visit unless otherwise indicated

Immunizations: ☐ Influenza (Annual) If available during Flu Season * ☐ Pneumococcal (every 5 years)*

Diagnostics: ☐ EKG ☐ Foot Exam* ☐ Mammogram (every 2 years) ☐ PAP Smears

☐ Fecal occult testing (50 yrs. and older) ☐ Other:

Treatment Goal if BP > 130/80

Short Term Goal: Patient will take all meds as ordered. Will notify medical staff of complications, such as headaches, visual changes, foot problems.

Long Term Goal: ≤125/75 mm Hg for patients with renal insufficiency and proteinuria ≥ 1 Gm/24 hours.

Long Term Goal: Patient will participate in facility program until release from facility without complications from his/her diabetes.

Compliance with treatment plan? ☐ YES ☐ NO

Education: ☐ Die ☐ Medication ☐ Exercise ☐ Disease Process ☐ Risk Factors and reducers

☐ Signs and symptoms to report ☐ Adaptation to the correctional environment ☐ Medication Compliance

Patient's Condition*: ☐ Poor ☐ Fair ☐ Good

Patient's Condition*: ☐ Stable ☐ Improving ☐ Deteriorating

Patient verbalizes understanding? ☐ YES ☐ NO

Interpreted by _____ ☐ Spanish ☐ Other _____ ☐ Not Applicable

_____

Clinician Signature/Title Date & Time

Rio Grande Detention Center Updated 7/2017

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DHS-ICE-20-0618-A-001952

ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan
(Follow up to the February 2017 FMC Site Visit)

Facility Name	**Rio Grande Detention Center**
Address (Street and Name)	**1001 San Rio Boulevard**
City, State and Zip Code	**Laredo, TX 78046**
County	**Webb**
Date[s] of FMC Site Visit	**February 21 - 24, 2017**
Complete and Return to ICE HQ No Later Than:	**September 14, 2017**

Facility Corrective Action Plan Assigned to	**Field Office**

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Date of Final Submission:
September 09, 2017

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the Field Office must contact the appropriate DMD staff member with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (February 2017 FMC site visit) Rio Grande Detention Center (SNA)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
[PBNDS 2008 Standard Deficiency] Several health appraisals were performed greater than 14 days after arrival to the facility (Medical Care)(V)(J).	(b)(5)	The Health Services Administrator discussed with staff the importance of proper and timely scheduling the health appraisals prior to day 14 to allow for them to be completed (See Attachment 1). The 3 LVNs not in attendance are PRN and the findings will be discussed with them when they report for duty.	August 30&31 2017

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		GEOtrack now schedules new arrivals for their health appraisals on day 13 upon their arrival to the facility. If the appointment is missed, then the medical record/date entry clerk reschedules the health appraisal as a priority for day 14. The QA Nurse is now monitoring this requirement through the Medical QA Program for a period of 60 days.	
[PBNDS 2008 Standard Deficiency] Medical grievances are not tracked and logged in a Detainee Grievance Log (Grievance System)(V)(E).	(b)(5)	The Health Services Administrator discussed with staff the management and tracking of Medical Grievances (See Attachment 1). A Medical Grievance Log has been created and is being updated and maintained weekly by the DON (See Attachment 2).	August 30 & 31, 2017
[CQI Finding] **REPEAT FINDING** The neurological history completed on a seizure patient was inadequate.		The Health Services Administrator discussed with staff that they must complete a neurological history during the initial chronic care appointment, to include onset of the seizures, history of head trauma, medication use/compliance, how well are	August 30 & 31, 2017

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	(b)(5)	seizures controlled on or off medications, when was the last seizure, and how the seizure manifested (See Attachment 1). Neurological Chronic Care Forms have been updated to include all neurological history during the Initial chronic Care appointment (See Attachment 3). This requirement is now being monitored by the Chronic Care Nurse through the Medical Quality Assurance Program for a period of 60 days.	
[CQI Finding] 50% of sick call encounters reviewed were seen greater than 72 hours from the date of triage.		The Health Services Administrator discussed with staff that sick call requests are to be triaged within 24 hours and detainees seen within 48-72 hours to demonstrate compliance with NCCHC standards (See Attachment 1). Sick Calls are now being triaged and monitored by the CCS/QA nurse, with outcomes reported to the HSA weekly. The Sick Call process is now being monitored by the assigned QA	August 30 & 31, 2017

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		nurse through the Medical QA program for a period of 60 days.	
[CQI Finding] 40% of the lab work reviewed by the FMC did not have an appropriate clinical response documented.	(b)(5)	The Health Services Administrator discussed with staff that abnormal labs results must have an appropriate clinical response documented within the medical record (See Attachment 1). The new Chronic Care Nurse, as a matter of practice, is now monitoring abnormal lab results and flagging them for the providers' reviews and responses to be documented in the medical records. This requirement is now being monitored by the new Chronic Care Nurse through the Medical QA program for the next 60 days.	August 30 & 31, 2017
[CQI Finding] 80% of charts did not show documentation that the detainee was notified of lab results.		The Health Services Administrator discussed with staff that the patients need to be educated on the results of any lab work performed at the facility, to include documenting such education in the medical records (See Attachment 1). New notification Forms have been	August 30 & 31, 2017

AMERICAN OVERSIGHT

		developed and implemented (See Attachment 4). This requirement is now being monitored by the assigned QA nurse for 60 days through the Medical QA program.	
I[CQI Finding] Intake blood sugars were not consistently recorded on detainees claiming to have diabetes.	(b)(5)	The Health Services Administrator discussed with staff that blood sugars should be measured during the medical intake for any detainee claiming to be diabetic (See Attachment 1). Intake forms (see attached) have been modified to include a field for recording blood sugars when applicable. This requirement is now monitored by the assigned QA nurse for 60 days through the Medical QA program.	August 30 & 31, 2017
[CQI Finding] Several detainees received delayed chronic care (greater than 14 days from arrival).		The Health Services Administrator discussed with staff that health appraisals on detainees with chronic illness are to be prioritized and, at minimum; these detainees are to be seen for chronic care prior to day 14 from arrival (See Attachment 1).	August 30 & 31, 2017

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		The new Chronic Care Nurse is now prioritizing all chronic care patients to be seen within 14 days from arrival. This requirement is now monitored by the assigned QA nurse for 60 days through the Medical QA program.	
[CQI Finding] Baseline HgA1C lab work is not being done within 30 days of arrival on diabetic detainees.	(b)(5)	The Health Services Administrator discussed with staff that the HgA1C is to be collected within the first 30 days from arrival on all diabetic detainees (See Attachment 1). New Chronic Care Forms have been modified to include HgA1C lab work (See Attachment 6). This requirement is now monitored by the Chronic Care Nurse for 60 days through the Medical QA program.	August 30 & 31, 2017
[CQI Finding] Two hypertension charts reviewed were not seen for chronic care and care was not consistent with a clinical practice guideline. Lab work, EKG, blood pressure monitoring were not ordered.		The Health Services Administrator discussed with staff that they are required to follow Clinical practice guidelines, to include performing lab work, obtaining EKGs, and monitoring blood pressure for all hypertensive chronic care patients (See Attachment 1).	August 30 & 31, 2017

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		This requirement is now monitored by the assigned QA nurse through the Medical QA program for 60 days.	
[CQI Finding] A serum drug level was not ordered on a detainee taking anti-convulsant medication.	(b)(5)	The Health Services Administrator discussed with staff the requirement for obtaining serum drug levels during the initial chronic care work-up for seizure patients who take anticonvulsant medication. New Chronic Care Forms have been implemented for Seizure patients (See Attachment 3). This requirement is now monitored by the Chronic Care Nurse for 60 days through the Medical QA program.	August 30 – 31, 2017

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Attachment 1

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Health Services Department Monthly Meeting

(August 30 & 31, 2017 - 0700)

1. Medication Carts/Trash/Sharp Containers
   - Need to be cleaned out daily.

2. Staffing - Job Vacancy

(b)(6); (b)(7)(C); (b)(7)(E)

3. ICE Audit
   - The corrective action plans (CAPS) included training for staff - see attached training conducted

4. NCCHC Audit
   - Response includes training of health service staff - see attached training conducted.

5. Monthly Tally and audit sheets are due by COB, September 1, 2017.

6. GEO Training
   - The on-line training is to be completed by the COB, August 31st - this is mandatory training and will affect your work schedule if not completed.

7. Overtime/KRNONOS clock
   - Prior approval of all overtime must be obtained from (b)(6); (b)(7)(C)
   - Charge RN must inform the DON/HSA of any emergencies that resulted in OT
   - Shifts start at the top of the hour – you are expected to clock in on time and report to your post. The 7 minute grace period is for the occasional issue not the norm.

8. ICE Labs
   - All ICE labs tests must have prior approval from ICE
   - There will be a separate log book for ICE labs
   - Medical Records will work from this log and submit the required MEDPAR
   - Medical Records will track the approvals and ensure when it is received they are noted in the log book
   - Blood draws will be done once the MEDPAR approval is noted in the log book
   - MEDPARs will be done for biopsies/cultures, but do NOT wait to collect and send. Patient care is first and foremost.

9. Costal Bend Evacuation
   - AWESOME JOB EVERYONE - We managed 329 CB detainees as the professional team that we are. Thank you
     1. There will be an after-action meeting next week and I need your input - if you have any concerns regarding the process/procedures let me know so we can improve for the next time. Also look at what if we had to evacuate RGDC - Is there something we need to ensure is on our to do list. Email me your suggestions. Thank you again for a job well done!!!

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RIO GRANDE DETENTION CENTER
HEALTH DEPARTMENT
ICE/CQI Meeting
August 2017

- In February 2017 ICE Health Service Corps (IHSC) Audit was conducted.
- There was a total of 12 Finding that required a Corrective Action Plan
- Training was conducted on the following Assessments and Finding.

Assessment and Finding

1. Several health appraisals were performed greater than 14 days after arrival to the facility
   - **Training conducted**-- The health services staff have been trained and educated on the importance of properly and timely scheduling the health appraisals several days prior to day 14 to allow for them to be completed.
2. Medical grievances are not tracked and logged in a Detainee Grievance Log
   - **Training conducted**- The health services staff have been trained on management of keeping track of Medical Grievances. The log has been created and is updated and maintained by the DON.
3. The neurological history completed on a seizure patient was inadequate
   - **Training conducted**-- The clinical providers and health services staff have been trained and educated on assessment and documentation of neurological patient. They must complete a neurological history during the initial chronic care appointment. Including when did seizures start, history of head trauma, medication use/compliance, how well are seizures controlled on or off medications, when was the last seizure, how does the seizure manifest (generalized, partial, etc).
4. 50% of sick call encounters reviewed were seen greater than 72 hours from the date of triage.
   - **Training conducted**-- The health services staff have been trained and educated that sick call requests are triaged within 24 hours and seen within 48-72 hours in order to be in compliance with NCCHC standards.
5. 40% of the lab work reviewed by the FMC did not have an appropriate clinical response documented.
   - **Training conducted**-- The clinical providers and the health services staff have been trained and educated that abnormal labs results have to have an appropriate clinical response documented within the medical record.
6. 80% of charts did not show documentation that the detainee was notified of lab results.
   - **Training conducted**-- The clinical providers and the health services staff have been trained and educated that the patients' needs to be notified and educated the detainee's on their results of any lab work done at the facility. The education should be documented in the patient's medical record.
7. Intake blood sugars were not consistently recorded on detainees claiming to have diabetes.
   - **Training conducted**-- The clinical providers and the health services screening nurses have been trained and educated that blood sugars should be measured during the medical intake on any detainee claiming to be diabetic. The new Intake forms now have a sections where they can document the Intake blood sugar checks.

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8. Several detainees received delayed chronic care (greater than 14 days from arrival).
    - **Training conducted** -The clinical providers and the health services staff have been trained and educated on health appraisals on detainees with chronic illness be prioritized and at minimum be seen for chronic care prior to day 14.(Currently ICE Chronis's are seen within 7 days)
9. Baseline HgA1C lab work is not being done within 30 days of arrival on diabetic detainees.
    - **Training conducted-** The clinical providers and the health services staff have been trained and educated that an HgA1C be collected within the first 30 days on all diabetic detainees as per RGDC clinical practice guidelines.
10. Lab work, EKG, blood pressure monitoring were not ordered.
    - **Training conducted-** The clinical providers has been trained and educated on the appropriately follow clinical practice guidelines. The new Chronic Care forms now include all the labs, EKG, and diagnostics that are needed per clinical guidelines.
11. The neurological history completed on a seizure patient was inadequate.
    - **Training conducted-** The clinical providers has been trained and educated on the appropriately follow that seizure patients receive a complete neurological history during the initial chronic care appointment.
12. A serum drug level was not ordered on a detainee taking anti-convulsant medication.
    - **Training conducted-**The clinical providers has been trained and educated on the importance of ordering serum drug levels be obtained as part of the initial chronic care work-up on seizure patients who take anticonvulsant medication, as appropriate.

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CCS
CORRECT CARE

RGDC DEPARTMENT MONTHLY MEETING - AUGUST 2017

Print Name and Title	Sign Name
(b)(6); (b)(7)(C)	

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CORRECT CARE

RGDC DEPARTMENT MONTHLY MEETING - AUGUST 2017

PRINT NAME/TITLE	SIGNATURE
(b)(6); (b)(7)(C)	

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 8/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? Bureau Of Prisons Clinical Practice Guideline

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	NO	YES	YES
8		NA	NA	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	9 / 9 100 %	8 / 9 89 %	10 / 10 100 %	10 / 10 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

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CHRONIC DISEASE – SEIZURE DISORDER

DATE 8/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? Reports No CPG for Sz

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	6 / 6 100 %	8 / 8 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

Revised September 2016

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001968

CONTINUITY OF MEDICATION

DATE 08/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item # Measure

1 Period of time from completion of intake screening to the ordering of medications less than 24 hours?

2 Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 10 %	10 / 10 10 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001969

DENTAL CARE

DATE 9/1/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item # Measure

1 Was patient screened for symptoms during the intake process?
2 Was patient evaluated by a qualified health professional within 48 hours of request?
3 Do dental clinical notes describe findings, diagnosis, treatment and plans?
4 Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	YES	NA
6		YES	YES	YES	NA
7		YES	YES	YES	NA
8		YES	YES	YES	NA
9		YES	YES	YES	NA
10		YES	YES	YES	NA
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	0 / 0 0 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001970

CHRONIC DISEASE – DIABETES

DATE 09/01/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? BOP CPG

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care within seven days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within the past 3 months?
4	Were lipids measured within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated? *
7	Was degree of control (goal HgbA1C <7.0) documented?
8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	N/A	YES	YES	YES	YES	NO	YES	N/A
2		YES	YES	YES	YES	YES	YES	YES	N/A
3		N/A	YES	YES	YES	YES	N/A	YES	YES
4		YES	YES	YES	YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES	YES	N/A	N/A
6		YES	YES	N/A	YES	YES	N/A	N/A	N/A
7		YES	YES	YES	YES	YES	N/A	YES	N/A
8		YES	YES	YES	YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES	N/A	YES	YES
10		N/A	YES	YES	YES	YES	YES	YES	N/A
	Total	7 /7 100 %	10 /10 100 %	9 / 9 100 %	10 /10 100%	10 /10 100 %	5 6 90 %	8 /8 100 %	4 / 4 100 %

KEY: NA= not applicable

*Refer to User Guide for clinical indications.

NCCHC Guidelines for Disease Management, Diabetes, (April 2013). http://www.ncchc.org/guidelines

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 8/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item #	Measure
1	Is there an outbound progress note?
2	*Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3	Is there discharge documentation from the hospital or ED in the chart?
4	Is there an inbound assessment?
5	Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Chronic Wound	YES	NO	YES	YES	YES
2		Hyperglycemia	YES	YES	YES	YES	YES
3		Chest Pain	YES	NO	YES	YES	YES
4		Seizure	YES	NO	YES	YES	YES
5		Chest Pain	YES	NO	YES	YES	YES
6		Hyperglycemia	YES	NO	YES	YES	YES
7		Seizure	YES	NO	YES	YES	YES
8		Chest Pain	YES	NO	YES	YES	YES
9		Chest Pain	YES	NO	YES	YES	YES
10		R/O Seizure	YES	NO	YES	YES	YES
			10 / 10 100 %	1 / 10 10 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised September 2016

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001972

HEALTH ASSESSMENT

DATE 8/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	NA	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	NA	YES	YES
10		YES	NA	NA	YES	YES
	Total	/ %	/ %	/ %	/ %	/ %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 8/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP CPG

Item #	Measure
1	How was HIV status identified? By laboratory, prior medical records or patient report?
2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?Was
3	patient seen by an HIV or ID specialist within 30 days of HIV identification?
4	Was antiretroviral treatment considered and documented?
5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Patient Interview	YES	NA	YES	NA	YES
2		Patient Interview	YES	YES	YES	NA	YES
3		Patient Interview	YES	NA	YES	YES	YES
4		Patient Interview	YES	NO	NA	NA	NO
5		Patient Interview	NA	NA	YES	NA	YES
6		Patient Interview	YES	YES	YES	NA	NO
7		Patient Interview	YES	NA	YES	NA	YES
8		Patient Interview	YES	YES	YES	YES	YES
9		Patient Interview	NA	YES	YES	YES	YES
10		Patient Interview	YES	YES	YES	YES	YES
	Total		8 / 8 100 %	5 / 6 83 %	9 / 9 100 %	4 / 4 100 %	8 / 10 80 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001974

MEDICATION ADMINISTRATION PRACTICES

DATE 9/1/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 3%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 70%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	1	NA	NA
2		1	NA	NA
3		0	NA	NA
4		0	NA	NA
5		1	NA	NA
6		3	YES	YES
7		0	NA	NA
8		0	NA	NA
9		9	YES	YES
10		3	NA	NA
	Total		2 /2 100%	2 /2 100%

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 8/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	NA
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	9 / 9 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001976

SUICIDE SCREENING

DATE 8/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 84

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ☑ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ☑ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	At least q 15 min	YES	NO
4		YES	YES	At least q 15 min	YES	NO
5		YES	YES	At least q 15 min	YES	NO
6		YES	YES	At least q 15 min	YES	NO
7		YES	YES	At least q 15 min	YES	NO
8		YES	YES	Constant (1:1)	YES	NO
9		YES	YES	At least q 15 min	YES	NO
10		YES	YES	At least q 15 min	YES	NO
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	0 / 0 0 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 1/30/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADELANTO DETENTION FACILITY

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? BOP CPG

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	NA	YES
3		YES	YES	NA	YES
4		YES	YES	NA	YES
5		YES	NA	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	NA	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	9 / 9 100 %	6 / 6 100 %	10 / 10 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 02/03/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 41

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	14	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	8	
Delay(s) in care	12	
Competency/professional skillset of medical staff	2	
Attitude, demeanor or conduct of staff		
Other	5	(b)(6); (b)(7)(C)
Total	41	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATION

DATE 02/01/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facilitiy

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed September 2016

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001980

DENTAL CARE

DATE 02/02/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-001981

CHRONIC DISEASE – DIABETES

DATE 01/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADELANTO

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? Bureau of Prisons CPC

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within the past 3 months? Were lipids measured
4	within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated? *
7	Was degree of control (goal HgbA1C <8.0) documented?
8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	N/A	YES	YES	N/A
2		NA	YES	YES	YES	YES	YES	YES	N/A
3		YES	YES	YES	YES	N/A	YES	YES	YES
4		YES	YES	YES	YES	N/A	YES	YES	YES
5		YES	YES	YES	YES	N/A	YES	YES	YES
6		YES	YES	YES	YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES	N/A	YES	YES
10		YES	YES	YES	YES	YES	YES	YES	YES
	Total	9 /9 100 %	10 /10 100 %	10 /10 100 %	10 /10 100 %	6 /6 100 %	9/9 100 %	10 /10 100%	8 / 8 100 %

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 02/01/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item #	Measure
1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	General Surgery	YES	YES	NO	YES
2		Gastroenterology	YES	YES	YES	YES
3		Oncology	YES	N/A	YES	YES
4		Other radiology	YES	N/A	N/A	N/A
5		urology	YES	YES	N/A	YES
6		Neurology	YES	YES	YES	YES
7		Orthopedics	YES	YES	YES	YES
8		Other urology	YES	YES	YES	N/A
9		Other radiology	YES	YES	N/A	N/A
10		Gastroenterology	YES	YES	N/A	NO
		Total	10 / 10 100%	8 / 8 100%	5 / 6 83 %	6 / 7 85 %

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE January 31, 2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item #	Measure
1	Is there an outbound progress note?
2	*Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3	Is there discharge documentation from the hospital or ED in the chart?
4	Is there an inbound assessment?
5	Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	CP	YES	NO	YES	YES	YES
2		syncope	YES	NO	YES	YES	YES
3		psychosis	YES	NO	YES	YES	YES
4		psychosis	YES	NO	YES	YES	YES
5		Abdominal pain	YES	NO	YES	YES	YES
6		DVT	YES	NO	YES	YES	YES
7		psychosis	YES	NO	YES	YES	YES
8		DVT	YES	NO	YES	YES	YES
9		Seizure	YES	NO	YES	YES	NO
10		hypotension	YES	NO	YES	YES	YES
			10 / 10 100 %	0 / 10 0 %	10 / 10 100 %	10 / 10 100 %	9 / 10 90 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised September 2016

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DHS-ICE-20-0618-A-001984

HEALTH ASSESSMENT

DATE 1/31/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	NA	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	NA	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	1 / 1 100 %	5 / 5 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

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HEALTH ASSESSMENT

DATE 1/31/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

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2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	NA	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	NA	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	NA	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	20 / 20 100 %	/ %	10 / 10 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

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CHRONIC DISEASE – HIV

DATE 1/30/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP Clinical Practice Guide

Item # Measure

1. How was HIV status identified? By laboratory, prior medical records or patient report?
2. Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3. Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4. Was antiretroviral treatment considered and documented?
5. Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6. Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Patient Interview	NA	YES	YES	NA	YES
2		Patient Interview	YES	YES	YES	YES	YES
3		Patient Interview	YES	YES	YES	YES	YES
4		Patient Interview	YES	YES	YES	YES	YES
5		Patient Interview	YES	YES	YES	YES	YES
6		Patient Interview	YES	YES	YES	YES	YES
7		Patient Interview	YES	YES	YES	YES	NO
8		Patient Interview	YES	YES	YES	NA	YES
9		Patient Interview	YES	YES	YES	YES	YES
10		Recent Lab	NA	NA	NA	NA	NA
	Total		8 / 8 100 %	8 / 8 100 %	8 / 8 100 %	7 / 7 100 %	8 / 9 89 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

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DHS-ICE-20-0618-A-001987

CHRONIC DISEASE – HYPERTENSION

DATE 02/03/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADF

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? BOP CPG

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	N/A	YES
2		YES	YES	N/A	YES
3		YES	YES	YES	YES
4		YES	YES	N/A	YES
5		YES	YES	N/A	YES
6		YES	YES	N/A	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	10 / 10 100 %	10 / 10 100 %	3 / 3 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

May 21, 2018

MEMORANDUM FOR: Tae Johnson
ERO Assistant Director
ICE Custody Management

THROUGH: (b)(6); (b)(7)(C)
ERO Assistant Director
ICE Health Service Corps
(b)(6); (b)(7)(C)

FROM: (b)(6); (b)(7)(C)
IHSC Deputy Assistant Director
Health Care Compliance Branch
(b)(6); (b)(7)(C)

SUBJECT: Report of ICE Health Service Corps Subject Matter Expert Team Visit - Adelanto ICE Processing Center - March 6 to 8, 2018

Executive Summary:

Between March 6 and 8, 2018, a subject matter expert (SME) team of ICE Health Service Corps (IHSC) Officers (IHSC Team – see Appendix A) undertook a visit to the Adelanto ICE Processing Center (AIPC) to: 1) evaluate the status of healthcare at the site; and 2) to assist and offer recommendations to the primary subcontractor, GEO and its subcontracted health care provider, Correct Care Solutions (CCS), regarding systemic processes that may be hindering provision of necessary and appropriate medical care.

The IHSC Team findings indicate serious noncompliance with several PBNDS standards including, the leadership and the quality assurance program; pharmaceutical management; medical record keeping practices; and the mental health program. Other important deficiencies involve aspect of dental and medical care. IHSC Team found, although to a lesser degree, deficiencies in meeting PBNDS pertaining to sick call practices; clinical evaluation and management; disability; and medical grievances. These last four areas are not listed or discussed in the report.

The IHSC Team provides recommendations toward future improvements in and sustained compliance with the described PBNDS standards.

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Full Report

Between March 6 and 8, 2018, a subject matter expert (SME) team of ICE Health Service Corps (IHSC) Officers (IHSC Team) undertook a visit to the Adelanto ICE Processing Center (AIPC) to evaluate the status of healthcare at the site. The IHSC Team's visit followed-up deficiencies in health service delivery cited by the U.S. Department of Homeland Security's Office for Civil Rights and Civil Liberties (CRCL) after its on-site investigation in November 2017. The IHSC Team's visit was also intended to assist and offer recommendations to the primary subcontractor, GEO and its subcontracted health care provider, Correct Care Solutions (CCS), regarding systemic processes that may be hindering provision of necessary and appropriate medical care. The composition of the IHSC Team is listed below (Appendix A).

This report is based on, among other things, on record reviews; use of the Quality of Medical Care (QMC) toolkit; interviews with facility and corporate principals; and observations of clinical and administrative practices. The scope of the report is limited to AIPC's compliance with the ICE Performance-based National (PBND) Standards (PBNDS) 2011, required of AIPC under the Intergovernmental Service Agreement (IGSA) with the City of Adelanto.

Findings.

***Note**: Below are listed several values indicating the proportions of medical records found deficient with regards to PBND standards in relation to the number of records reviewed to assess particular standards. These values represent a screening method commonly used as a method of program monitoring and evaluation (M&E) and a means to identifying areas of deficiencies requiring greater scrutiny by other methodologies (e.g., 100% record review and audits). By design, this screening method in not intended to represent statistical analyses.*

***Note**: This report has been abbreviated to address only those deficiencies in health care delivery specific to PBND standards 2011. Standards deficiencies deemed of lesser import per the screening method utilized and as compared to those described below, are not discussed in this report.*

Leadership and Quality Assurance (QA)

1. PBNDS 4.3 V.EE.2.e.7. *The Health Systems Administrator (HSA) shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program. The CMA (Chief Medical Authority, together with the HAS, establishes the processes and procedures necessary to meet the medical standards outlined herein.*

2. PBNDS 4.3 V.EE.2.e.7. *The HSA shall implement a system of internal review and quality assurance. The system shall include… (e) on-site monitoring of health service outcomes on a regular basis through the following measures… (7) reevaluating problems or concerns, to determine whether the corrective measures have achieved and sustained the desired results.*

Leadership, or the persons responsible for the administrative and clinical matters that support the facility's management and care delivery, is significantly deficient in establishing processes and procedures for fundamental elements of any medical program, primarily in the areas **quality assurance (QA) program**, **pharmaceutical management, medical record-keeping practices** in

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particular the facility's **electronic health record (eHR)**], and **mental health program** (see corresponding sections below).

QA processes have been unable to ensure effectiveness of corrective actions in many areas requiring improvement. This is based on an examination of the minutes, (data collection, analyses, and subsequent presentations of results and recommendations considered at AIPC's quarterly Continuous Quality Improvement (CQI) Committee meetings in 2017), along with historical knowledge as it reflects on current problems and concerns at AIPC.

Discussion.

Because the information being tracked and intervened upon at the direction of the CQI Committee has been, for the most part, chosen from findings in audits and reports of prior site visits, upon prior adverse events, external audits, and investigations, the facility's Leadership, and by extension, the QA program is essentially and continuously attempting to correct issues in a reactive manner and retroactively. Even under these circumstances, CQI activities are insufficient in informing improvement actions for current problems and concerns, but more importantly from a prospective view.

It should be noted that the current administrative and clinical leadership was kept on by CCS when healthcare delivery at AIPC was subcontracted to them in early 2017; however, deficiencies in leadership were evident and have been documented before CCS health services began to provide health services at Adelanto.

Quality assurance. A definition of a QA program is one that consists of activities and programs intended to assure or improve the quality of care in either a defined medical setting or a program. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.

The IHSC visit made evident that the information being tracked and intervened upon has been, and for the most part, chosen in reaction to prior findings by external entities. Thus, the facility's Leadership, and by extension, the QA program, is consuming a large part of its effort in continuously attempting to correct issues on-the-spot, leaving little room for proper M&E efforts that might better serve the improvement of current and future problems.

In addition, a number of QA activities instituted to address problems under study by the CQI Committee have not been effective and/or whatever improvement achieve sustainable over time, and part of the reason may be because such QA activities have not been assessed for effectiveness post implementation. For example, medical grievances, which although trended, discussed, and intervened upon at the direction of the CQI Committee, demonstrate a wide fluctuation in the proportion of grievances received in the four quarters (Q) of 2017 (Q1 -20%, Q2 -10%, Q3 - 28%, and Q4 -11%). The number that were "late" were reported as zero for the entire year of 2017 in the graphics presented.

Prominent among the unidentified root causes of problems and concerns include the relatively small number of incident reports generated for any issues, such as medication errors, that may have been encountered. For example, and although the medication administration record (MAR) issues are trended, the causes of errors and other findings are not, except in very few cases such as "Psychotropic

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Medications Tracking" (a separately tracked topic). With respect to the latter, the only regularly tracked information of potential clinical usefulness is the number of psychotropic medication prescribed and renewed. With respect to the former (the MAR), only administrative matters such as number of MARs audited are tracked.

Recommendations:

(b)(5)

Pharmaceutical Management

1. PBNDS 4.3. V.G.12. *Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: 12. documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders.*

2. PBNDS 4.3. V.G.10. *Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: (10) supervision by properly licensed personnel.*

In a review of ten psychiatric patient charts, 100% of MARs printed from the pharmacy contained previously discontinued orders that were not recorded as such in the MAR. Each of the MAR records reviewed had an average of four discontinued but still active orders. This means that the patient may have been administered the same medication more than once and/or in higher dosage within the prescribed period. In a review of ten medical care-specific records, 60% of printed MARs contained discontinued but still active orders.

In addition, in an interview of the HSA regarding pharmaceutical management in AIPC, he stated and his statement collaborated by the posted organization chart that the medication procurement and administration process at AIPC is currently overseen by an licensed vocational nurse (LVN).

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The purpose of any institutional policy is to provide staff with the compulsory parameters of and for their duties.

Discussion:

Medication administration represents practices of high frequency and potentially serious adverse outcomes. For example (see also below), the MAR of a detainee with mental illness contained four orders for quetiapine, three of which had been discontinued at least two months previously, and three orders for hydroxyzine, two of which had been discontinued the previous month. Drug-drug interaction for these two medications produces additive sedation; and although a rare side-effect, it increases the risk of an irregular heart rhythm that may be serious and potentially life-threatening.

Furthermore, during the interview with the author, one of the members of the AIPC QA team (an LVN) stated, "*I am not comfortable in passing out pills at pill line because you never know if the medication, the dosage, or the quantity is correct in the MAR.*"

Medication management documentation errors seriously diminish AIPC's capability for accountability of medication administration. Medication administration and record documentation errors (see medical record keeping practices below) were recounted proximal to a patient death by the ICE Office of Detention Oversight (ODO) Detainee Death Report. In their report ODO documents that one day before his death by suicide, a detainee in segregation had already refused his psychiatric medications for 48 hours (a twice-a-day medication) and for 24 hours (a once-a-day medication). In an ODO team member's interview with the HSA, the HSA acknowledged that the nurse failed to follow AIPC's medication administration policy by not notifying a provider after the detainee missed three doses of any medication. In addition, the facility psychologist, who had visited the detainee approximately three hours before his death, was not aware that the patient was not compliant with his medications at the time because the information was not available to him at the time. It is not clear whether or not these errors may have contributed to the detainee's death.

Recommendations

(b)(5)

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(b)(5)

Medical Record-Keeping Practices

PBNDS 4.3 V.BB. *The HSA shall maintain a complete health record on each detainee that is: organized uniformly in accordance with appropriate accrediting body standards; available to all practitioners and used by them for health care documentation; and properly maintained and safeguarded in a securely locked area within the medical unit.*

Inadequate standardization of policies and procedures for and use of the eHR results in unnecessary searches for information within the system, the potential loss of information because of parallel systems of data management, diminished capacity for the accountability of clinical and administrative functions, and for performing QA activities that require routinely-collected information.

Discussion:

1. Loss of information. Instead of entering information directly into the eHR's structured fields, where the information can be reliably found and used for multiple administrative and clinical purposes, information in the form of filled-out paper forms and other physical documents are frequently scanned into the eHR as non-searchable versions and in non-standardized target locations. This practice constitutes a "work-around," or parallel process of data management that can result in unnecessary, if non-productive, searches for information within the system, and potential loss of information within and exterior to the electronic system.

2. Accountability for clinical and administrative functions. A record review found that seven (23%) of 30 records reviewed listed detainees as being in residence, when in fact, they had left the facility 20 days prior. Incorrect data and reports emanating from these data, as generated by the her, not only cripple any type of visit appointment system, but also the availability of and accountability for essential information such as laboratory results, correct administration of medication, and even detainee physical location. Further, the perception of inaccuracies in the eHR diminishes staff trust in the system, and often results in the creation of additional work-arounds that are subject to a greater degree

3. Continuity and quality of care. With the underuse of the eHR, the efficient, reliable and accountable tracking, analysis, trending, and reporting of information is significantly diminished. It also makes the production of structured reporting for the purposes of quality and enhancement of health care delivery, and administrative and clinical functions become more cumbersome and time-consuming, and therefore inefficient.

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Recommendations:

(b)(5)

Mental Health Program

PBNDS 4.3 V.N.3. *Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day. Such evaluation and screenings shall include: (b). history of any mental health treatment or evaluation; (c) history of illicit drug/alcohol use or abuse or treatment for such; and (d) history of suicide attempts.*

Nine (90%) records of ten reviewed had any mention that the provider had reviewed the medical records for presence of a history of mental health illness prior to the patient encounter. No record reviewed made mention by any mental health provider of drug or alcohol history.

Discussion:

With respect to the documentation by a mental health provider of drug or alcohol history, one particular record reviewed made no mention of the detainee's "*extensive alcohol use, recent DUI and recent detoxification treatment*" history documented elsewhere.

Lack of documentation affirming or negating either the availability of a prior record for review or having elicited a history of mental illness and/or substance abuse would not meet compliance with this standard, since it cannot be verified. Failure to find such information may also be dependent on the deficient standardization of the eHR medical record.

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Recommendations:

(b)(5)

Dental Assessments

PBNDS 4.3 V.R. *An initial dental screening shall be performed within 14 days of the detainee's arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.*

Three (33%) of ten records reviewed did not meet the requirement for a dental screening to be done within 14 days of detainee's arrival.

Recommendation:

(b)(5)

Medical Care

PBNDS 4.3 V.U.5. *Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications.*

Two (20%) of ten records reviewed indicated that the detainees did not receive their medication within 24 hours.

Discussion:

One of the records reviewed showed that one detainee went without cardiac medications for 2-3 days until seen by a provider. The medication was not provided because the detainee's personal supply was in Russian

Recommendation:

(b)(5)

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(b)(5)

Disability

PBNDS 4.8 V.F.4.e. *Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations*

PBNDS 4.8 V.F.4.g. *After the facility has completed its review of a detainee with a disability or of a request for an accommodation, facility staff shall place written documentation of the following in the detainee's medical and/or detention file.*

Six (33%) of 20 detainee records reviewed were missing appropriate accommodation orders (special needs). Additionally, AIPC does not clearly determine in-record-progress-notes if the provider has assessed the detainees for assistance with activities of daily living.

Recommendation:

(b)(5)

Conclusion

AIPC continues to experience difficulty in meeting PBND standards of health care. In the opinion of the IHSC Team, a concerted effort by AIPC to ensure that (1) strong leadership is in place; (2) the QA program is strengthened and modified to ensure it ability to identify—most importantly prospectively— the correct problems to intervene upon, focusing on processes and procedures; and

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evaluate the effectiveness and sustainability of QA interventions implemented to improve deficiencies; (3) Foster a "just" (non-punitive) culture to improve input from and reporting by all staff regarding areas they see as needing improvement; (4) the eHR be optimized to its fullest capacity; (5) the QA program, routine staff training, and regular in-services on standards and best practices of care hold top priority for the administrator and medical director; and (6) peer review-particularly involving mental health—is strengthened.

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Appendix A

Composition of the ICE Health Service Corps (IHSC) Subject Matter Expert Team:

- CAPT (b)(6); (b)(7)(C) MD (Lead), Deputy Assistant Director for Health Care Compliance
- CAPT (b)(6); (b)(7)(C) Deputy Assistant Director for Health Systems Support (HSS)
- (b)(6); (b)(7)(C) MD, Chief of Psychiatry, IHSC
- CAPT (b)(6); (b)(7)(C) Unit Chief for Medical Case Management
- CDR (b)(6); (b)(7)(C) PharmD; IHSC staff pharmacy consultant \
- CAPT (b)(6); (b)(7)(C) IHSC Field Medical Coordinator
- CDR (b)(6); (b)(7)(C) IHSC Field Medical Coordinator
- (b)(6); (b)(7)(C) IHSC Risk Manager

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

Facility Information				
Facility Name:	Adelanto ICE Processing Center			
AOR:	LOS			
Address:	10400 Rancho Road			
City:	Adelanto		**County:**	San Bernardino
State:	CA	**Zip:**	82301	
Inspection Information				
Start Date:	3/6/2018			
End Date:	Select			
Organization:		IHSC		
# Detainees at Time of Visit:		1534		
Total Facility Population at Time of Visit:		1534		
Facility Capacity:				
Notes:	The Adelanto ICE Processing Center (APC) is an ICE dedicated IGSA with only detainees. APC operates under The Geo Group Inc. which contracts with Correct Care Solutions (CCS) to provide on-site medical care.			
Reviewer Information				
Lead Reviewer Name:	**CAPT** (b)(6); (b)(7)(C)		**Date Signed:**	3/24/2018
Signature:	X			

HQ Use Only:

~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	95%	
CG	Complaints and Grievance	9	*Total Number
CM	Continuity of Medications	90%	
DC	Dental Care	100%	
DM	Diabetes	94%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	76%	
HA	Health Assessment	99%	
HIV	Human Immunodeficiency Virus	96%	
HTM	Hypertension	98%	
LT	Laboratory Testing	72%	
MR	Medical Recordkeeping	44%	
MAR	Medication Administration Records	95%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	90%	
SS	Suicide Screening	75%	
TD	Treatment of Disability	93%	
UC	Urgent Care (Sick Call)	96%	

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IGSA STAFFING MATRIX						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Lab Tech						
Other 2						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTM	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs (Medical Administrative Record).					
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm					
Remarks:	(b)(6); (b)(7)(C) Initial exam on 2-7-18 Peak flow performed on 2-22-18 (b)(6); (b)(7)(C) Initial exam on 3-6-17. Peak flow performed on 3-29-17.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/6/2018	
Facility (f)						
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y	
fASM-1b:	If yes, what is the guideline?		BOP CPG			
Clinical (c)						
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cASM-2	Was a peak flow completed at the initial physical exam?					
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?					
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.					

Totals:	10	10	8	10	10			
Compliance:	95%	100%	80%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	Yes	Yes	Yes			
4		Yes	Yes	Yes	Yes			
5		Yes	Yes	N/A - LOS	Yes			
6		Yes	Yes	N/A - LOS	Yes			
7		Yes	Yes	Yes	Yes			
8		Yes	No	Yes	Yes			
9		Yes	No	Yes	Yes			
10		Yes	Yes	Yes	Yes			

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:	10								
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.								
Source:	Chronic disease registry or MARs.								
Sample:	10 patients with diabetes chosen at random, if available.								
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines								
Remarks:	Patient #3 with HTN, DM, F, 47 y.o. - not on ASA; ok?; #4 with 5-6 instances of low BS 37-52 +sx and no change in meds - on Lantus 56u, 1000mg Metformin; s/s reg insulin; hgbA1c 8.5.								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	3/6/2018				
Facility (f)									
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP Clinical Practice Guidelines							
Clinical (c)									
cDM-1	Was blood sugar measured and recorded on intake?								
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)								
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?								
cDM-4	Were lipids measured within one year?								
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?								
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.								
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?								
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?								

Totals:	10	9	10	9	10	9	9	9	10
Compliance:	94%	90%	100%	90%	100%	90%	90%	90%	100%

Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	No	Yes	Yes	Yes	No	Yes	Yes	N/A - NLOS
2		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS
3		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	No	Yes
4		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
5		Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
9		N/A	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes

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HIV

Number of Files Reviewed for Patients Meeting this Criteria:	10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	(b)(6); (b)(7)(C) illness identified on 7-20-17. Chest xray collected on 7-28-17. (b)(6); (b)(7)(C) illness identified on 1-31-17, chest xray completed on 5-26-17.						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/6/2018			

Facility (f)

fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP CPG

Clinical (c)

cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
cHIV-4	Was antiretroviral treatment considered and documented?
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?

Totals:	10		10	10	10	10	8
Compliance:	96%		100%	100%	100%	100%	80%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	Yes	Yes	Yes	Yes
2		Patient Interview	Yes	Yes	Yes	Yes	Yes
3		Patient Interview	Yes	Yes	Yes	Yes	Yes
4		Patient Interview	Yes	Yes	Yes	Yes	No
5		Patient Interview	Yes	Yes	Yes	Yes	Yes

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
6	(b)(6); (b)(7)(C)	Recent Lab	Yes	Yes	Yes	Yes	No	
7		Patient Interview	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
8		Patient Interview	Yes	Yes	Yes	Yes	Yes	
9		Patient Interview	Yes	Yes	Yes	Yes	Yes	
10		Patient Interview	Yes	Yes	Yes	Yes	Yes	

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HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:	10							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/6/2018			
Facility (f)								
fHTM-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y			
fHTM-1b:	If yes, what is the guideline?		BOP Clincal Practice Guideline					
Clinical (c)								
cHTM-1	Was a blood pressure reading noted at intake?							
cHTM-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTM-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTM-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Totals:	10	9	10	10	10			
Compliance:	98%	90%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cHTM-1**	**cHTM-2**	**cHTM-3**	**cHTM-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	N/A - NLOS	Yes			
3		Y	Yes	N/A - NLOS	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	N/A - NLOS	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	N/A - NLOS	Yes			
9		N	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:	6					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) day at 5 weeks. Refused sz meds and labs. Had chronic care f/ups. (b)(6); (b)(7)(C) no thorough neurohx at initial exam. (b)(6); (b)(7)(C) No thorough neurohx.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/6/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	Reports No CPG for Seizure				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Totals:	6	4	5	6	6	6
Compliance:	90%	67%	83%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	No	N/A - LOS	N/A - LOS	Yes
2		No	Yes	N/A - LOS	Yes	Yes
3		Yes	Yes	N/A - LOS	Yes	Yes
4		No	Yes	N/A - LOS	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7						
8						
9						
10						

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CONTINUITY OF MEDICATIONS									
Number of Files Reviewed for Patients Meeting this Criteria:		10							
Purpose:	To assess timeliness of medication, as ordered.								
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).								
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.								
Guidelines:									
Remarks:	Type Text Here								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	3/7/2018				
Clinical (c)									
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?								
cCM-2	Period of time from order to first dose less than 24 hours?								
Totals:	10	8	10						
Compliance:	90%	80%	100%						
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		No	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		No	Yes						
10		Yes	Yes						

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:	10							
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/7/2018				
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Totals:	10	10	10	10	10			
Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	N/A - NLOS			
2		Y	Yes	Yes	N/A - NLOS			
3		Y	Yes	Yes	N/A - NLOS			
4		Y	Yes	Yes	N/A - NLOS			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	N/A - NLOS			

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:	(b)(6); (b)(7)(C) Urology; (b)(6); (b)(7)(C) Retina Specialist; (b)(6); (b)(7)(C) Oral Surgeon					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/7/2018		
Clinical (c)						
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?					
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?					
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?					
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?					
Totals:	10		10	10	10	10
Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**
1	(b)(6); (b)(7)(C)	Infectious Disease	Yes	N/A - NLOS	Yes	Yes
2		Orthopedics	Yes	Yes	Yes	Yes
3		Orthopedics	Yes	Yes	Yes	Yes
4		Neurology	Yes	N/A - LOS	N/A - LOS	N/A - LOS
5		Orthopedics	Yes	N/A - LOS	N/A - LOS	N/A - LOS
6		Other	Yes	Yes	Yes	Yes
7		Orthopedics	Yes	Yes	Yes	Yes
8		Other	Yes	Yes	N/A - NLOS	Yes
9		Infectious Disease	Yes	Yes	Yes	Yes
10		Gastroenterology	Yes	Yes	Yes	Yes

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE							
Number of Files Reviewed for Patients Meeting this Criteria:	10						
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.						
Source:	Emergency Department (ED) logs.						
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.						
Guidelines:	NCCHC 2014 J-E-12.						
Remarks:	(b)(6); (b)(7)(C) No asessment on return (b)(6); (b)(7)(C) No assmnt on return, no intake screen (b)(6); (b)(7)(C) No inbound assmnt. A "NO" answer in the cEED-2 question is the desired answer = met criteria; Therefore should be 100% met for that column.						
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	3/8/2018	
	Clinical (c)						
cEED-1	Is there an outbound progress note?						
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.						
cEED-3	Is there discharge documentation from the hospital or ED in the chart?						
cEED-4	Is there an inbound assessment?						
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?						
Totals:	10		10	0	10	8	10
Compliance:	76%		100%	0%	100%	80%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
1	(b)(6); (b)(7)(C)	chest pain	Yes	No	Yes	Yes	Yes
2		meth withdrawal	Yes	No	Yes	Yes	N/A - LOS
3		mandible fracture	Yes	No	Yes	No	Yes
4		chest pain	Yes	No	Yes	Yes	Yes
5		renal calculi	Yes	No	Yes	Yes	Yes
6		URI	Yes	No	Yes	No	Yes
7		seizure	Yes	No	Yes	N/A - LOS	N/A - LOS
8		cellulitis	Yes	No	Yes	Yes	Yes
9		illegal drug use	Yes	No	Yes	Yes	Yes
10		rule out Bell's palsy/stroke	Yes	No	Yes	Yes	Yes

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:	36						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	Facility Grievance log reviewed from December 2017 - February 2018						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/7/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			36			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			32			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	9	0	0	9	0	1	1
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
1	(b)(6); (b)(7)(C)	0	0	0	0	0	1
2		0	0	1	0	0	0
3		0	0	1	0	0	0
4		0	0	1	0	0	0

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
5	(b)(6); (b)(7)(C)	0	0	0	0	1	0
6		0	0	1	0	0	0
7		0	0	1	0	0	0
8		0	0	1	0	0	0
9		0	0	1	0	0	0
10		0	0	2	0	0	0

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	(b)(6); (b)(7)(C) chest xray not read within 72hrs due to "housing issues." Cxray was ordered five days after arrival. Cxray completed nine days after arrival.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/8/2018	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Totals:	20	20	19	20	20	20
Compliance:	99%	100%	95%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	Yes
2		Yes	Yes	N/A	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	N/A - LOS	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	No	Yes	Yes	Yes
10		Yes	N/A	N/A	Yes	Yes
11		Yes	Yes	N/A	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	N/A	Yes	Yes
14		Yes	Yes	N/A	N/A - NLOS	Yes
15		Yes	Yes	Yes	Yes	Yes
16		Yes	Yes	N/A	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess timeliness, continuity, and coordination of care.					
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.					
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.					
Guidelines:						
Remarks:	Lack of documentation of teaching on lab results = trend; delays in lab drawing of routine labs due to list is full - 1-2 weeks from date desired.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/7/2018	
Clinical (c)						
cLT-1	Was blood drawn or test done within 1 business day of ordered date?					
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?					
cLT-3	Was there clinical acknowledgment?					
cLT-4	Was there an appropriate clinical response?					
cLT-5	Was patient advised of laboratory results?					
Totals:	10	6	10	9	10	1
Compliance:	72%	60%	100%	90%	100%	10%

Patient(s)	A# (numbers only)	cLT-1	cLT-2	cLT-3	cLT-4	cLT-5
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	No
2		Yes	Yes	No	N/A - NLOS	No
3		Yes	Yes	Yes	Yes	No
4		No	Yes	Yes	Yes	No
5		No	Yes	Yes	Yes	No
6		No	Yes	Yes	Yes	No
7		Yes	Yes	Yes	Yes	No
8		Yes	Yes	Yes	Yes	No
9		Yes	Yes	Yes	Yes	Yes
10		No	Yes	Yes	Yes	No

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS				
Number of Files Reviewed for Patients Meeting this Criteria:	10			
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.			
Source:	MARS.			
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.			
Guidelines:				
Remarks:	Type Text Here			
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/6/2018
Facility (f)				
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?			Y
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?			30
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?			0
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.			75
fMAR-5:	OTCs provided by medical, commissary or both?			Both
Clinical (c)				
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?			
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?			
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)			

Totals:	10	38	10	9
Compliance:	95%		100%	90%

Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS
2		0	N/A - NLOS	N/A - NLOS
3		1	N/A - NLOS	N/A - NLOS
4		30	Yes	No
5		6	Yes	Yes
6		0	N/A - NLOS	N/A - NLOS
7		1	N/A - NLOS	N/A - NLOS
8		0	N/A - NLOS	N/A - NLOS
9		0	N/A - NLOS	N/A - NLOS
10		0	N/A - NLOS	N/A - NLOS

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(b)(6);
(b)(7)(C)

MEDICAL RECORD-KEEPING PRACTICES																						
Number of Files Reviewed for Patients Meeting this Criteria:		10																				
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.																					
Source:	Medical Records, Chronic Care Log, and MARs.																					
Sample:	10 records of detainees with chronic disease, if available.																					
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."																					
Guidelines:	NCCHC 2014 J-H-01, J-H-03.																					
Remarks:	2 of the 10 charts reviewed were inactive, but in eCW were listed as active.																					
Reviewer:				**Date Reviewed:**	3/7/2018																	
			Facility (f)																			
fMR-1:	Type of Medical Records?		Both																			
fMR-2:	Name of Electronic Health Record?		eCW																			
Totals:	10	10	7	7	7	3	0	8	0	10	2	1	0	1	2	10	5	10	0	0	10	0
Compliance:	44%	100%	70%	70%	70%	30%	0%	80%	0%	100%	20%	10%	0%	10%	20%	100%	50%	100%	0%	0%	100%	0%

Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A
2		Compliant	Partial Compliance	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A
3		Compliant	Non-Compliant	Compliant	Partial Compliance	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A
4		Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A
5		Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	N/A
6		Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A
7		Compliant	Compliant	Partial Compliance	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	Compliant	N/A
8		Compliant	Non-Compliant	Partial Compliance	Partial Compliance	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	N/A
9		Compliant	Compliant	Partial Compliance	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	N/A
10		Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	N/A

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:	10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/6/2018				
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Totals:	10	10						
Compliance:	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		Yes						
3		Yes						
4		Yes						
5		Yes						
6		Yes						
7		Yes						
8		Yes						
9		Yes						
10		Yes						

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	Type Text Here								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/7/2018				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Totals:	10	10	10						
Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

AMERICAN OVERSIGHT

PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:	2					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/6/2018	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Totals:	2	2	2	2	2	2
Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	A "NO" answer for question cSS-5 is the desired answer = met criteria; therefore the total compliance for that column should read 100%. - noted by CAPT Hanton					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/8/2018		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		43			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Totals:	10		10	10	10	0
Compliance:	75%		100%	100%	100%	0%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	At least q 15 min	Yes	Yes	Yes	No
2		At least q 15 min	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	N/A - LOS	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		At least q 15 min	Yes	Yes	Yes	No
6		At least q 15 min	Yes	Yes	Yes	No
7		At least q 15 min	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		At least q 15 min	Yes	Yes	Yes	No
10		At least q 15 min	Yes	Yes	Yes	No

AMERICAN OVERSIGHT

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TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:	10					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/7/2018	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Totals:	10	10	10	7	10	
Compliance:	93%	100%	100%	70%	100%	
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	N/A - LOS	Yes	N/A - NLOS	
2		Yes	N/A - LOS	No	N/A - NLOS	
3		Yes	N/A - LOS	Yes	N/A - NLOS	
4		Yes	N/A - LOS	Yes	N/A - NLOS	
5		Yes	N/A - LOS	Yes	N/A - NLOS	
6		Yes	N/A - LOS	No	N/A - NLOS	
7		Yes	N/A - LOS	Yes	N/A - NLOS	
8		Yes	N/A - LOS	No	N/A - NLOS	
9		Yes	N/A - LOS	Yes	N/A - NLOS	
10		Yes	N/A - LOS	Yes	N/A - NLOS	

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)							
Number of Files Reviewed for Patients Meeting this Criteria:	10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.						
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
Remarks:	Type Text Here						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/6/2018		
Clinical (c)							
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
cUC-2	Was care delivered within the scope of the nurse's license?						
cUC-3	Were vital signs documented during the nurse's assessment?						
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
Totals:	10		10	10	10	8	10
Compliance:	96%		100%	100%	100%	80%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
1	(b)(6); (b)(7)(C)	spine, neck, back pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
2		fever and headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
3		flu symptoms	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
4		headache and bodyaches	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
5		leg pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
6		Difficulty sleeping	Yes	Yes	Yes	Yes	Yes
7		groin rash	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
8		abdominal pain	Yes	Yes	Yes	No	N/A - NLOS
9		rib pain	Yes	Yes	Yes	No	N/A - NLOS
10		leg pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 02/02/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		NO	YES	YES	YES	YES
9		NA	NO	NO	NO	NA
10		NA	NO	NO	NO	NA
	Total	7 / 8 88 %	8 / 8 100 %	8 / 8 100 %	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002028

MEDICAL RECORDKEEPING PRACTICES

DATE 02/03/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADF

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☐ Electronic ☑ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Partial compliance	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	NA	Compliant	Compliant	Compliant	Compliant
Flowsheets	NA	NA	Compliant	Compliant	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	Compliant	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	NA	Compliant	Noncompliant	Partial compliance	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Noncompliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	NA	Compliant	Partial com	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 02/03/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADF

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☐ Electronic ☑ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Noncompliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	Noncompliant	Noncompliant	NA	Compliant	Compliant
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Noncompli	Compliant	Compliant	Compliant	Noncompli
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

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MEDICATION ADMINISTRATION PRACTICES

DATE 02/01/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 1%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 70%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		2	NA	NA
4		0	NA	NA
5		0	NA	NA
6		0	NA	NA
7		0	NA	NA
8		2	NA	NA
9		0	NA	NA
10		3	YES	YES
	Total		1 /1 100%	1 /1 100%

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE January 31. 2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanton Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised September 2016

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE January 29, 2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto detention Facility

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	NO
2		YES	YES
3		YES	NA
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	NA
10		YES	NA
	Total	10 / 10 100 %	6 / 7 86 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002033

INTAKE EVALUATION: PREGNANT WOMEN

DATE 1/31/17 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA	YES	YES
2		YES	YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES	YES
5		YES	YES	YES	NA	YES	YES
6		YES	YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	8 / 8 100 %	10 / 10 100 %	10 / 10 100 %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002034

CHRONIC DISEASE – SEIZURE DISORDER

DATE 1/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED ADELANTO DETENTION FACILITY

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? BOP CPG

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	7 / 7 100 %	7 / 7 100 %	6 / 6 100 %	7 / 7 100 %	7 / 7 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

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DHS-ICE-20-0618-A-002035

SUICIDE SCREENING

DATE January 31, 2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Detention Facility

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 66

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ☑ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ☑ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		YES	YES	Constant (1:1)	YES	NO
9		YES	YES	Constant (1:1)	YES	NO
10		YES	YES	Constant (1:1)	YES	NO
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 02/03/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Adelanto Detention Facility

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA
2		YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	10 / 10 100 %	10 / 10 100 %	0 / 0 0 %	0 / 0 0 %

KEY: NA = not applicable

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URGENT CARE (SICK CALL)

DATE 02/01/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto detention Facility

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	stomach pain	YES	YES	YES	YES	YES
2		flu	YES	YES	YES	NO	N/A
3		pain	YES	YES	YES	YES	YES
4		eye problems	YES	YES	YES	YES	N/A
5		flu	YES	YES	YES	YES	YES
6		"can't walk"	YES	YES	YES	YES	YES
7		vision	YES	YES	YES	YES	YES
8		broken tooth	YES	YES	YES	YES	YES
9		waist pain	YES	YES	YES	YES	YES
10		reflux	YES	YES	YES	YES	YES
		Total	10 / 10 100%	10 / 10 100%	10 / 10 100%	9 / 10 90 %	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.

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ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan
(FMC Site Visit February 2017)

Facility Name **Adelanto Detention Facility**
Address (Street and Name) **10250 Rancho Road**
City, State and Zip Code **Adelanto, CA 92301**
County **San Bernardino**
Date[s] of FMC Follow-up ***30 days of receipt of approved CAP***
Complete and Return to ICE HQ No Later Than: **7/13/2017**

Facility Corrective Action Plan Assigned to: AFOD (b)(6); (b)(7)(C)

~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

Report produced on 6/29/2017. Revised 11/15/17

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Date of Final Submission:

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Site Visit Reviews) Adelanto Detention Facility (LOS AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
Deficiency: PBNDS 2011 4.3.4 Of the nine HIV charts reviewed, there was: one out of nine (11%) of detainees with HIV who had a chest x-ray completed within 72 hours of problem identification. The one detainee did not disclose his HIV status upon intake or during his physical. Once he did disclose his HIV status, medications, labs and follow-up was ordered however; chest x-ray	(b)(5)	1. On May 17, 2017, the Clinical Director held a staff meeting. During the staff meeting Clinical Practice Guidelines to include Management of HIV were discussed with the providers. 2. A full review of all the HIV detainees currently at Adelanto was reviewed on June 15, 2017 to determine if	Meeting: Completed May 17, 2017. June 15, 2017

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was not completed.		they have chest x-rays. 3. To ensure compliance, each new detainee arriving at Adelanto will be reviewed to ensure a chest x-ray is completed. Each newly diagnosed HIV patient will be reviewed to ensure compliance with the Clinical Practice Guidelines. The review will be completed by the Chronic Care QA Nurse until compliance is established for three consecutive months. 4. The data will be reported by the QA nurse to the Clinical Director and Health Services Administrator to ensure compliance. 5. The data will be reported on a quarterly basis to the CQI Committee. **FMC November 2017 Update:** Continued finding during the August 2017 site visit; refer to the CAP for additional updates. **FMC February 2019 Update:** Continued finding during the March 2018 FMC Site Visit	CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		refer to the CAP for additional updates. **FMC February 2019 Update:** Compliant during the September 2018 FMC Site Visit.	
Quality of Care Issue: Of the ten sick call charts reviewed, one out of ten (10%) charts reviewed revealed a nursing referral was not submitted within 24 hours when appropriate. One detainee was assessed during sick call was found to have a fever (100.4) and heart rate of 107. The nurse treated the detainee using nursing protocols however, unable to locate the completed nursing protocol form in medical record.	(b)(5)	6 a. The DON will schedule training for all RN's with the eCW Trainer on use of RNSC Nursing Protocols on eCW no later than May 15, 2017. The DON will provide training for all RN's on individualized focused nursing assessment using the established RNSC protocols. The training will be conducted no later than May 15, 2017. b. The DON will provide training for all RN's on triage utilizing guidelines established. The training will be conducted no later than May 15, 2017. c. The DON will provide training for all RN's on proper scheduling of triaged sick call requests to ensure compliance with NCCHC and PBNDS. The	Completed: May 15, 2017 Completed: May 15, 2017 Completed: May 15, 2017.

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		training will be conducted no later than May 15, 2017. d.Training will be provided by the DON for all new hires as they come in for "on-job-training." II. Procedure a. Nurses assigned to the 3rd watch (NOC shift) will collect the sick call requests from the sick call requests drop off boxes within the units. b. All sick call requests will be triaged upon receipt. The sick call will be date/time stamped upon receipt. c. The sick call requests will be scheduled based on urgency. d. All scheduled sick call will be evaluated on the day they are scheduled. The DON will review the schedule to ensure all	On-going

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		sick call request scheduled for the day are completed. The DON will designate a staff to ensure above is completed in their absence. III. QA and Follow-up a. On a daily basis, the DON will review a minimum sample size of 5 RN sick calls to ensure they are properly triaged, scheduled and evaluated following the established nursing protocols. In the absence of the DON, the DON will designate a reviewer. b. On a weekly basis, the report will be forwarded to the HSA and QA for the information to be collated, analyzed and trended for compliance. Corrective actions above will be reviewed if it does not correct the problem. On a quarterly basis, the	CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		report will be presented in the CQI meeting. **FMC November 2017 Update**: No issues identified during August 2017 site visit.	
Quality of Care Issue: Of the ten charts reviewed for evaluation of care provider to the emergency department/hospital visit, one out of ten (10%) charts revealed that the assessment did not reflect the hospital findings and concurrence or deviation from the hospital recommendations. One detainee was released from the hospital with a recommendation for a neurology follow-up in 3-4 weeks. The recommendation was not addressed timely.	(b)(5)	1. A roster of all detainees sent out to the local hospital/ED for the past six months (February -July 2017) will be requested from medical records by July 31, 2017. 2. A review of all detainees currently housed at Adelanto will be reviewed by the QA Nurse to ensure recommendations are being addressed by August 15, 2017. QA Plan: 1. All hospital/ED discharges are tracked by the Chronic Care QA Nurse on a daily basis. 2. The CC QA Nurse sends an e-mail to medical records to ensure records are reviewed by the provider and scanned into eCW within 24-48 hours of receipt.	Completion Date: July 31, 2017 Completion Date: August 15, 2017 CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		3. The CC QA Nurse will sample 5 hospital/ED discharges on a weekly basis to determine if the records were reviewed by a provider, recommendations implemented and the discharge notes scanned into eCW. 4. On a weekly basis, the findings will be provided to the Assistant Health Servcies Administrator and Clinical Director to ensure compliance. Data collection will continue until there is 12 consecutive weeks of demonstrated compliance. **FMC November 2017 Update**: No issues identified during August 2017 site visit.	
Quality of Care Issue: Ten charts were reviewed to further evaluate medical recordkeeping practices. Documents were not scanned into the appropriate section of the medical record consistently. For example consult notes were scanned into the consent section.	(b)(5)	The Assistant Health Services Administrator will provide a template as to what is to be scanned into each section of the patient documents into eCW. The template will be provided to all medical records clerks by July 31, 2017.	Completion date: July 31, 2017

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		The AHSA will educate all medical records clerk on scanning of documents into the right sections of the patient documents based on the template. The education will be completed by August 7, 2017. QA Plan: 1. On a weekly basis, a sample of 10 health records will be reviewed by the QA Nurse to ensure patient documents are scanned into the right sections of the eCW. 2. The report will be forwarded to the AHSA by the QA nurse on a weekly basis to ensure compliance. 3. The report will be reported to the CQI Committee every three months. The data collection will continue until there is demonstrated compliance for 12 consecutive weeks. **FMC November 2017 Update**: No issues identified during	Completion date: August 7, 2017 CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive 12 has been established.

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		August 2017 site visit.	
Quality of Care Issue: One chart had medications listed on the MAR but unable to find orders for medications . The verbal order was not signed off by the provider.	(b)(5)	On February 7, 2017, a procedure for entering Telephone/Verbal Orders was sent out to staff by the Health Services Administrator. Clinical staff receiving the Telephone Order/ Verbal Order (TO/VO) will enter the order in the message section and send the TO/VO to the provider for review. The provider will review the TO/VO and cosign the order. (On June 1, 2017, a follow up email from the eCW Coordinator was sent to all RN and Provider Staff with proper instructions on entering TO/VO into eCW) QA Plan: 1. The Medical Director reviews TO/VO actions for all providers on a weekly basis to verify the provider staff clear the actions and cosigns the	Completion Date: February 7, 2017. Follow-up e-mail on June 1, 2017. CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks

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		note. 2. A sample of 5 TO/VO orders from each provider will be checked on eCW to ensure if TO/VO are addressed by the provider. 3. The weekly tracking data will be collated and reported to the CQI Committee once a week to monitor compliance. The data will be reported during the quarterly CQI meeting. The data will continue to be collected, aggregated and evaluated for compliance until there is demonstrated compliance for 12 consecutive weeks. **FMC November 2017 Update:** CQI reports indicate issue remains unresolved. FMC will continue to monitor. **FMC February 2019 Update:** As of the March 2018 FMC site visit TO/VO sign offs compliant.	has been established.
Quality of Care Issue: Of the charts reviewed for lab orders, one of eight (12%) charts revealed that an ordered lab was not drawn within the ordered time frame. The lab was ordered to be drawn on	(b)(5)	At this time, health services was in transition from paper records to electronic records. The laboratory technicians	Completion Date of education: July 18, 2017 (completed)

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8/24/16; however, it was not drawn. A refusal was obtained and placed in the chart on 8/30/16.	(b)(5)	have been educated to ensure laboratory or refusals for laboratory studies are documented within the timeframe requested. They were reminded by email again on July 17, 2017. QA Plan: 1. On a weekly basis, a random sampling of 10 laboratory orders will be conducted by the QA nurse. The timeliness of the laboratory study will be checked to ensure the studies were drawn in the time frame ordered. 2. In the sampling, if a detainee refuses the study, the QA Nurse will check for a properly documented refusal form on eCW. 3. The data collected will be reported to the Assistant Health Services Administrator. Non-compliance will be addressed with the laboratory staff for	Completion Date: CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		immediate corrective action. 4. The data will be reported on a monthly basis to the Continuous Quality Improvement Committee. 5. The data will be collected until compliance is demonstrated for 12 consecutive weeks. **FMC November 2017 Update**: No issues identified during August 2017 site visit	
Quality of Care Issue: Of the charts reviewed for diagnostic services and specialty care access, one of six (17%) charts reviewed revealed that the detainee was not re-assessed by the provider at least every 30 days until the off-site service was completed.	(b)(5)	The Clinical Director will address all providers by July 31, 2017 that all detainees requiring non-routine specialty consultations will be followed up by the provider initiating the referral at least every 30 days until the off-site referral is completed. Procedure: 1. Upon writing of a Treatment Authorization Request (TAR) for , the provider will schedule the detainees for a follow-up	Completion Date: July 31, 2017

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		within 30 days of the initial TAR request and assess the detainee. 2. The provider will check the record (eCW) under the "R" tab to determine the appointment schedule. The detainee will then be scheduled for another appointment until seen by the specialist and detainee is followed up for recommended actions. QA Plan: 1. On a weekly basis, a roster of new Treatment Authorization Requests (TARs) will be generated by the QA Nurse. 2. A sample of 5 new TARs will be reviewed and compared to the provider schedule to determine if the detainees were scheduled for an evaluation within 30 days of the initial TAR. If a detainee is not scheduled a scheduled will be created by the QA Nurse for the detainee for a follow-up.	CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		3. The above sample will be checked 30 days thereafter by the QA Nurse to check if the detainee was assessed and/or the detainee has been followed-up post specialty consult. The same process will continue if the detainee has not been evaluated after the 30 day assessment until the detainee is evaluated by the specialist. 4. The data collected will be forwarded to the Medical Director to address any non-compliance. 5. The data will be reported to the Continuous Quality Improvement Committee on a monthly basis. 6. The data will be collected until there is a demonstrated compliance for 12 consecutive weeks. **FMC November 2017 Update:** Continued finding during the August 2017 site visit; refer to the CAP for additional updates. **FMC February 2019 Update:**	

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		As of the March 2018 FMC site visit diagnostic services and specialty care access compliant.	
Quality of Care Issue: One of seven (14%) charts reviewed revealed that the clinician did not acknowledge the specialist's report within seven days after the service was performed.	(b)(5)	The daily off-site referral are being tracked on a spreadsheet. The Assistant Health Services Administrator will follow-up with medical records and receive a report on a daily basis on the receipt and scanning of off-site specicalty consultation reports. An action to the provider for review of the reports will be sent for their review, and address the recommendations. A roster of all detainees sent out to the local specialist for the past six months (February -July 2017) will be requested from medical records by July 31, 2017. A review of all detainees currently housed at Adelanto will be reviewed by the QA Nurse to ensure recommendations are being	Completion Date: July 31, 2017 Completion date: August 15, 2017

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		addressed by August 15, 2017. QA Plan: 1. All detainees returning from specialty consultations are tracked by the Chronic Care QA Nurse on a daily basis. 2. The CC QA Nurse sends an e-mail to medical records to ensure records are reviewed by the provider and scanned into eCW within 24-48 hours of receipt. 3. The CC QA Nurse will sample 5 specialty referrals on a weekly basis to determine if the records were reviewed by a provider, recommendations implemented and notes scanned into eCW. 4. On a weekly basis, the findings will be provided to the Assistant Health Servcies Administrator and Clinical Director to ensure compliance.	CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		Data collection will continue until there is 3 consecutive months of demonstrated compliance. **FMC November 2017 Update:** Continued finding during the August 2017 site visit; refer to the CAP for additional updates. **FMC February 2019 Update:** As of the March 2018 FMC site visit diagnostic services and specialty care access in compliance.	
Quality of Care Issue: Of the mental health treatment planning charts reviewed, one out of seven (14%) did not have a treatment plan that was updated every 90 days. Although each detainee chart reviewed did have a complete assessment, treatment plan and follow-up plan documented, the formal mental health treatment plan was not completed on each detainee. The formal mental health treatment plan is one which includes identification of strengths, weakness, treatment goals and interventions.	(b)(5)	On February 2, 2017, CCS Divisional Mental Health Director conducted a training on mental health treatment plan for all the mental health providers. The mental health treatment plan development and review every 90 days was discussed with the Lead Mental Health Director on July 19, 2017. By July 31, 2017, the Lead Mental Health Director will address all mental health providers to	Completion Date: July 31, 2017

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		ensure a mental health treatment plan is completed at initial evaluation and reviewed every 90 days thereafter. A review of all detainees record with a chronic mental health diagnosis will be performed by the Mental Health Nurse by August 15, 2017. Detainees not having a treatment plan will be sent to the provider for initiation or review of the treatment plan. The mental health clerk will be advised to add a tab on the mental health tracking tool to address initial and 90 day review of the treatment plan. QA Plan: 1. On a weekly basis, the mental health nurse will sample 5 records of newly diagnosed detainees to determine if a treatment plan was initiated during initial evaluation. 2. On a weekly basis, the	Completion Date: August 15, 2017 CQI data collection continuous on a weekly basis until demonstrated compliance for 12 consecutive weeks has been established.

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		mental health nurse will sample 10 records of detainees over 90 days to determine if the treatment plan was reviewed. 3. The data collected will be provided to the Lead Mental Health Director and Health Services Administrator by the QA nurse on a weekly basis. The Lead Mental Health Director will address non-compliance. 4. The data will be reported to the Continuous Quality Improvement Committee on a monthly basis. 5. The data will be collected until there is demonstrated compliance for 12 continuous weeks. **FMC November 2017 Update**: No issues identified during August 2017 site visit	

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Corrections & Detention ®

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July 6, 2018

(b)(6); (b)(7)(C) PMP
Management and Program Analyst – COR
United States Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations
Los Angeles Field Office

Re: Adelanto ICE Processing Center
Response to Contract Discrepancy Report – IHSC Subject Matter Expert Team Visit March 6-8, 2018
Contract Number EROIGSA-11-0003

Dear (b)(6); (b)(7)(C)

On behalf of The GEO Group, Inc. (GEO), I write regarding Contract Discrepancy Report, dated June 4, 2018, from the Immigration Health Services Core (IHSC) Subject Matter Expert Team Visit March 6-8, 2018, to the Adelanto ICE Processing Center (AIPC). GEO values the strong partnership it enjoys with U.S. Immigration and Customs Enforcement's (ICE) Los Angeles Field Office, and GEO appreciates your trust and confidence in allowing our facility to support ICE's critical law enforcement mission.

GEO, and its medical provider (CCS), strive to quickly resolve concerns and maintain the highest-quality of service. As you know, our Chief Medical Officer, (b)(6); (b)(7)(C) and our Executive Vice President for Quality Control, Dr. (b)(6); (b)(7)(C) were on site for IHSC's visit in March 2018. They heard the concerns from Captain (b)(6); (b)(7)(C) and Captain (b)(6); (b)(7)(C) directly and immediately began addressing them. These issues have also been elevated to GEO's senior leaders. They have directed that every effort be made to quickly and effectively resolve each of the issues identified by IHSC. To further bolster the oversight of AIPC's medical department, CCS leadership has committed to hiring a full-time compliance manager to work at the facility and report directly to the CCS' corporate office. These compliance reports will also be shared, reviewed, and tracked by GEO. This CCS position will be above and beyond contracted staffing with no financial impact to ICE. We will work with ICE to full this position as

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quickly as possible. In addition, both Dr. (b)(6); (b)(7)(C) and Dr. (b)(6); (b)(7)(C) will continue to visit the Adelanto facility quarterly to provide oversight and training to the facility's health care staff.

While we acknowledge there are areas of the AIPC's operations that must and will be improved, AIPC's has successfully conducted more than 3,700 intakes and 3,600 releases since January 2018. Similarly, the AIPC's health services unit conduced over 6,000 health screenings and physicals during that same period. More than 6,000 mental health appointments were completed, and the AIPC's nursing staff dispensed medicine through more than 69,000 encounters.

Please see the corrective action plans attached to this letter. We have carefully reviewed each finding in this CDR and are aggressively working to solve each one with a sustainable corrective action plan that will generate lasting compliance. Further, we have initiated additional training sessions, created logs, verification steps, and used the talent management process to further support these efforts. Please see our response to each of the discrepancies identified detailed below. We will carefully monitor all findings as part of our continuing quality assurance process both at the AIPC and from a headquarters level.

We are committed to providing high-quality care to ICE's detainees housed at the AIPC. We look forward to your feedback on our corrective action plans, and we stand ready to clarify any areas where additional information would be helpful. If I can be of assistance, please contact me directly.

Respectfully,

(b)(6); (b)(7)(C)

James Janecka
Warden

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Findings

Finding: Medical Care, Section (V)(EE)(2)(e)(7)

"The HSA shall implement a system of internal review and quality assurance. The system shall include: (e) on-site monitoring of health service outcomes on a regular basis through the following measures: (7) reevaluating problems or concerns, to determine whether the corrective measures have achieved and sustained the desired results."

- An examination of CQI Committee meeting presentations revealed evidence that information being tracked and intervened upon are the results of prior adverse events, external audits, and investigation. Essentially, the medical program is correcting issues on-the-spot, but these issues are not informing the overall practice at the facility – this has led to the same or similar errors taking place overtime.
- Even though the electronic health record is one of the most crucial elements in maximizing the facility's ability to continuously improve quality of health delivery in complex medical settings, standardization for and staff proficiency in the use of the electronic health record has received no attention from the QA program since the electronic health record was introduced at AIPC.
- The above was further evident during interviews with staff members, where the Chief stated, "I would like to track medication errors, but it doesn't end up as a routinely collected measure or study because the Health systems administrator (HSA) is not focused on tracking."
- The overall QA program at the facility is further exacerbated by the poor recordkeeping practices, especially so with the medication administration record (further explained below). For example, the cause for many medication errors is the result of not tracking the cause for such errors and trending them overtime.

Plan of Action:

CCS leadership has given guidance to the AIPC's health services administrator (HSA) to generate and maintain a strong and sustained focus on the quality assurance (QA) program. Further, the HSA has been instructed to emphasize the inclusion of electronic health records (eHR) and administration of medication (MAR) in the facility's quality assurance program. At continuous quality improvement (CQI) meetings, the AIPC's staff continues to review and discuss the corrective action plans results that are effectively catching items that do not meet policy or performance standards. To memorialize these individual actions, the

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HSA created local operating procedures (LOPs) for each corrective action plan. The LOPs were discussed by the HSA during the staff meeting on June 26, 2018. In addition, the LOPs were electronically distributed to staff for their review and reference.

Following the IHSC visit, the CQI committee met and reviewed the AIPC's overall quality assurance (QA) plan to identify changes needed to enhance its effectiveness. The following areas were emphasized: emergency room and hospital visits and returns; routine specialty consultations and recommendations; the quality of the sick call procedure based on complaints and patients' medical histories; an overall review of grievances; staff training; a MAR "root cause" analysis review, and the addition of eHR performance in the QA plan.[1]

This comprehensive review of the QA plan resulted in the following actions:

- Effective the week of June 11, 2018, the primary care coordinator is responsible to collect, respond, and track medical grievances.

- Effective June 15, 2018, the HSA conducts a monthly audit of healthcare grievances to verify timely and accurate responses, in addition to evaluating the timeliness of care and access to care. Further, the HSA conducts a "root cause" analysis of each grievance to determine if there is a systemic quality of care issue. The results are reported in the monthly CQI meetings.

- Effective May 21, 2018, on a weekly basis, 20% of the specialty consultation, and emergency room hospital/returns are reviewed by the HSA or designee for quality of care and findings are discussed with the CQI committee to initiate corrective actions.

- Effective June 4, 2018, on a weekly basis, 10% of weekly sick call encounters are reviewed by the director of nursing (DON) or designee. A focused assessment is made on use of protocols, referrals to providers, and quality of care issues. The findings are discussed with CQI committee to initiate corrective actions for any quality of care issues.

As the CDR has specific findings on electronic health records and medication administration records, detailed responses to those findings are below.

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[1]The GEO Group's response to the U.S. Department of Homeland Security's Office for Civil Rights and Civil Liberties, dated June 13, 2018, and transmitted to ICE on June 14, 2018, provides additional detail on each of these areas.

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Attachment 1:

- April 25, 2018 CQI Agenda
- 2018 Hospital Visits and Returns / Routine Specialty Consults Log

Finding: Medical Care, Section (V)(B)

"The Health Systems Administrator (HSA) shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program. The CMA together with the HSA establishes the processes and procedures necessary to meet the medical standards outlined herein.

- Management and leadership establish the processes and procedures for the entire medical program. It is clear that these fundamental elements of any facility medical program are either non-existent or not followed at AIPC; therefore, it is reasonable to conclude that the findings contained herein lie at least partially on a lack of leadership oversight at the facility.
- It should be noted that the current administrative and clinical leadership remained at AIPC when health care delivery was subcontracted to CCS in early 2017.

Plan of Action:

To enhance the effectiveness of the AIPC's heath service department, on February 1, 2018, CCS commenced a process to recruit a seasoned physician with stronger leadership and management capabilities. While a physician was identified and we anticipated the candidate to start on June 18, 2018, as the new clinical medical authority, the individual ultimately declined the offer. As a result, CCS quickly restarted the recruitment process. In the interim, CCS leadership is providing additional training, mentoring, and oversight to the current provider.

Additionally, please note, the current HSA was hired in February 2016, and he was not the HSA prior to CCS becoming GEO's subcontractor. Finally, in April 2018, the assistant health services administrator (AHSA) was replaced. The new AHSA possesses strong experience with the QA process.

Finding: Medical Care, Section (V)(G) (12)

"Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: 12.

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documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders."

- The MAR and electronic health record are not communicating with one another. This leads to the provider and nursing staff not obtaining a complete picture of a detainee's care. As an example, the MAR of a detainee with mental health illness contained 4 orders for quetiapine, 3 of which had been discontinued at least 2 months previously, and 3 orders for hydroxyzine, 2 of which had been discontinued the previous month. The interaction for these two medications produces additive sedation; and although a rare side effect, it increases the risk of an irregular heart rhythm that may be serious and potentially life-threatening.
- In a review of 10 psychiatric patient charts, 100% of MARs printed from the pharmacy contained previously discontinued orders that were not recorded as such in the MAR.
- Additionally, in a review of 10 medical care-specific records, 60% of printed MARs contained discontinued orders.

Plan of Action:

A thorough review of this issue lead to the conclusion that the lack of medication reconciliation was tied to a specific psychiatrist. On June 5, 2018, this psychiatrist's user role in eClinicalWorks (eCW) was deleted and reset. Once this was completed, the psychiatrist was able to reconcile medications. Next, training on reconciliation of the medications on eCW was provided to this psychiatrist by the local CCS eCW administrator. As of July 5, 2018, all psychiatric patient medications were reconciled.

As noted above, AIPC includes the MAR process in its CQI efforts. The program features self-reporting of medication errors, review of MARs, identification of trends in medication errors, staff training, and counseling. Because of continued room for improvement in this area, immediately following IHSC's visit, on March 24, 2018, the HSA met with LVNs to discuss and reemphasize QA efforts directed at medication errors, proper documentation of patient records, and medication review on MARs. To ensure continued focus on this area, effective March 2018, and continuing monthly, medication-error vignette training is provided to all nurses. These issues are also discussed monthly at the CQI meetings.

To further increase visibility and oversight in this area, effective on April 2, 2018, on a daily basis, 10% weekly of MARs are reviewed by the AHSA and the QA nurse. The sampling encompasses all areas of the medication administration system. The review uses both a "failure mode and effect analysis" and "root cause

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analysis" to analyze the medication ordering, receipt, storage, and administration processes. In addition, 10% of weekly verbal or telephone orders are sampled and compared to the applicable MARs to determine the accuracy of transcription. Storage of stock medication and the proper documentation of use of stock medication on stock cards are also reviewed. Orders on the MARs are compared to current orders in the eCW to verify discontinued orders are recorded accurately. A trend analysis to determine the cause of medication errors is conducted to determine the root cause. Staff specific problems are addressed with performance improvement plans. As noted above, this study and monitoring are reported to the CQI committee monthly.

Attachment 2:

- Medication Training

Attachment 3:

- Medication Error Reporting Form
- Months 1-6, Medication Error Educational Vignettes

Finding: Medical Care, Section (V)(G)(10)

"Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: (10) supervision by properly licensed personnel."

- The above medication administration errors are compounded by (1) the lack of an onsite pharmacy; and (2) that the procurement and administration of medication at AIPC is directly overseen by a licensed vocational nurse – which is outside of the scope of practice for this position.

Plan of Action:

AIPC has a policy in place to manage pharmaceuticals. This policy is implemented through CorrectRx Pharmacy Services.[2] The prescription process is completed through e-prescription or faxing the order to CorrectRx who fills the medication order, and ships the stock cards to the facility. A licensed CorrectRx pharmacist, who conducts a quarterly visit and audit of the facility pharmacy,

[2] http://correctrxpharmacy.com/

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oversees the pharmacy. The LVN assigned to the pharmacy was solely in a quality assurance role. This LVN does not provide oversight in procurement and management of the pharmacy. GEO and CCS are currently reviewing the concept of having a clinical pharmacist on site at AIPC. While this would increase operating costs, there are potential savings that might offset some of the added expense. GEO plans to discuss this option with ICE soon.

Effective June 8, 2018, GEO and CCS discussed the viability of utilizing an electronic MAR system. GEO's management information systems specialist is in the process of conducting an assessment to determine the implementation requirements and I.T. security protocols. The assessment is anticipated to be completed by August 15, 2018. Any additional resource requests will also be completed for consideration.

Attachment 4:

- Policy on Pharmaceutical Operations
- Policy on Medication Services

Finding: Medical Care, Section (V)(BB)

"The HSA shall maintain a complete health record on each detainee that is: organized uniformly in accordance with appropriate accrediting body standards; available to all practitioners and used by them for health care documentation; and properly maintained and safeguarded in a securely locked area within the medical unit.

- Much like the MAR, the underutilization of the electronic health record and the use of work arounds outside of the system results in a high propensity for errors and loss of information. Essentially, the AIPC medical program is using three parallel systems: (1) the MAR; (2) the electronic health record; and (3) the manual scanning of paper-based documents into the electronic health record.
- The manual scanning of paper-based records into the electronic health record results in the loss of system functions, such as the ability to schedule, search, and find information; and requires the manual extraction of routinely collected data from multiple sources within the electronic health record. For example, currently, the facility conducts intake screening on paper, which consists of 13 pages for males and 15 pages for females; and once

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completed, the paper forms are scanned into the EHR by medical records staff, sometimes days later. Forty intakes per day, therefore, would be expected to produce approximately 600 pages requiring scanning.

- During a record review, the IHSC Team member investigating the use of the EHR (eCW) found that 7 (23%) of 30 records reviewed listed detainees as being in residence, when in fact they had left the facility over 20 days prior. Incorrect data or reports generated by the EHR, which would assist in determining, for example; detainees require mandatory physical exam 14 days into detention, currently requires a manual back up, or work-around process.

Plan of Action:

On March 12, 2018, a comprehensive review of eCW was initiated by information technology professionals and the medical team. All aspects of the eCW were reviewed, particularly as this system relates to MARs and paper-based records. A plan to reduce the use of paper-based records scanned into eCW was developed. In addition, the medical-intake screening template screen was updated. On April 24, 2018, the HSA trained applicable staff on the use of the revised electronic intake template. The electronic intake form went "live" on May 5, 2018. In addition, templates for medical history, physicals, chronic care clinics, and nursing protocols were reviewed. As a result of the reviews, structured data was incorporated into the chronic care templates. Quick reference guides were developed and have been strategically placed in AIPC's West and East intake areas, nursing area, and satellite offices for easy reference. Medical provider reference training videos were also created and saved on the shared drive for easy access by providers.

As of June 5, 2018, all intakes, chronic care encounters, acute visits, mental health visits, history and physicals, nursing protocols, and other encounters are captured electronically using templates or smart forms. In addition, a training lesson plan was developed and is used as a guide for all new and existing staff. A staff refresher training course will be completed by July 15, 2018. Three staff members have also been identified to attend "eCW Superuser" training. On a weekly basis, QA staff, to include the HSA, review a random sampling of 20 medical records to verify compliance. The review verifies the use of templates, and smart forms. The results are collected and analyzed to determine staff training needs, system reporting enhancements, development of smart forms or templates, and opportunities to further expand the conversion of paper documents into electronic form. This review is an on-going process, and is reported by QA staff at the CQI committee meeting monthly.

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Finally, as of May 1, 2018, all technological issues preventing the inmate movement database (GEOTrack) from accurately updating the eCW with the detainees' current location have been resolved.

Attachment 5:

- Sample Electronic Intake Template
- Quick Reference Guides

Finding: Medical Care, Section (V)(N)(3)

"Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee is evaluated by a mental health provider within the next business day. Such evaluation and screenings shall include: (b). history of any mental health treatment or evaluation; (c) history of illicit drug/alcohol use or abuse or treatment for such; and (d) history of suicide attempts."

- Nine (90%) records of 10 reviewed by the IHSC Chief Psychiatrist had any mention that the provider had reviewed medical records for presence of a history of mental health illness prior to the patient encounter. No record reviewed made mention by a mental health provider of drug or alcohol history, despite documentation of "extensive alcohol use, recent DUI and recent detoxification treatment."

Plan of Action:

The medical intake screening is now an electronic format, allowing providers to immediately review a patient's history prior to the encounter. The medical and mental health intake screen forms have questions which can trigger the need for a mental health referral. In addition, any detainee can request to see mental health by submitting a request and being seen through the daily sick call process. The request is submitted to the mental health nurse who schedules an appointment within 72 hours in the eCW. Appointments and follow-up appointments are scheduled and monitored through the eCW.

Effective June 11, 2018, on a daily basis, the mental health nurse reviews 5 daily encounters to verify compliance. The mental health nurse verifies if the detainee reported a history of mental health issues or substance abuse and if there is any

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evidence of a drug or alcohol abuse notated in the file from other sources (e.g., intake screening questionnaire, case notes, DUIs, drug related convictions, etc.). If any of these factors are present, the mental health nurse verifies that the detainee was evaluated within the required timeframe. Any issues identified through this process are reported to the HSA and immediately addressed with the responsible provider. On a weekly basis, the mental health nurse reports the findings to the lead mental health director and the QA coordinator for evaluation of cause. The information is analyzed and trends are identified to determine the reasons for delays or gaps in services. This review will continue on an ongoing basis. The information is tracked and reported to the CQI committee monthly.

Attachment 6:

- eClinical Works - Review Actions Console

Finding: Medical Care, Section (V)(R)

"An initial dental screening shall be performed within 14 days of the detainee's arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider."

- Three (33%) of 10 records reviewed were not in compliance with the specified time frame for a dental assessment.

Plan of Action:

Effective May 15, 2018, on a weekly basis the dental assistant runs a roster of newly arrived detainees for scheduling dental screening within 14 days of arrival. In the event that a dentist is on leave, the second dentist covers both facilities to perform dental screenings and emergency care. On a weekly basis, the QA nurse reviews the roster of intakes to determine compliance for medical history and physicals, and dental screening. The data is reviewed by the QA nurse weekly and trended to determine cause of any non-compliance. The above corrective action will be modified depending on the data trending and analysis on an ongoing basis. The information is tracked and reported to the CQI committee monthly. As of June 5, 2018, during May reviews 123 newly arrived detainees were reviewed, and verified to have all screenings provided as required.

Finding: Medical Care, Section (V)(C)(2)

"Screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines. All new arrivals shall

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receive TB screening within 12 hours of intake and in accordance with CDC guidelines."

- One (5%) of nineteen records reviewed did not have tuberculosis screening completed as per CDC guidelines. The chest x-ray was ordered five days after arrival and not completed until nine days after arrival. Failure to achieve 100% of the requirement of this standard places both detainees and staff at higher risk of tuberculosis infection, particularly given the origins of the detained population.

Plan of Action:

Importantly, CCS identified this issue prior to the IHSC review. On February 28, 2018, the symptom screening and TB screening was addressed with staff. Next, on April 1, 2018, an additional nurse was assigned to augment the current infection control nurse (ICN). On April 5, 2018, a new tracking spreadsheet was initiated to more efficiently track TB screenings. As of April 2, 2018, on a weekly basis the ICN reviews the intake packet for all detainees who arrived the previous day. The ICN inputs all PPD information on a spreadsheet which tracks PPDs conducted at intake and annual TB screenings. On a weekly basis, the ICN sends a copy of the spreadsheet to the QA nurse. The QA nurse performs a random sampling of 10 intake records to verify compliance. The information is trended, and any staff non-compliance is addressed by the DON or AHSA. In addition, on April 24, 2018, during the staff meeting, the HSA reiterated proper TB screening procedures and documentation. The information is reported quarterly to the CQI committee and will continue on an ongoing basis.

Attachment 7:

- February Meeting Minutes

Finding: Medical Care, Section (V)(S)(4)

"[A]n established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem."

- Two (67%) of three records reviewed for urgent care (sick call) did not have a nursing referral to a provider submitted within 24 hours where appropriate.

Plan of Action:

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On April 24, 2018, during the staff meeting, the HSA reviewed the use of nursing protocol templates in eCW. The triage guidelines and RN sick call referrals were also discussed. The DON or designee train new nursing staff during "on the job" training regarding the sick call triage process and the use of guidelines.

Effective June 11, 2018, the DON or designee reviews the daily schedule to verify all sick call requests scheduled for the day were completed. Any emergent or urgent referrals are sent to the provider immediately or the local emergency room if the doctor in not available. Non-emergent referrals are scheduled for the providers within the required time frame.

Effective June 11, 2018, on a daily basis, the DON or designee reviews a minimum of 5 RN sick calls to verify they are properly triaged, scheduled, and evaluated. On a weekly basis, the results are sent to the QA nurse for the information to be analyzed. On a quarterly basis, the report is presented to the CQI committee, and will continue to be tracked by the QA nurse.

Finding: Medical Care, Section (V)(U)(5)

"Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications."

- Two (20%) of ten records reviewed indicated that the detainees did not receive their medication within 24-72 hours. For example, one of the detainee's medication was not ordered at intake because the personal supplies were in Russian. The detainee went without several cardiac medications for 2-3 days until seen by a provider.

Plan of Action:

On June 26, 2018, during the staff meeting, medical staff were re-trained on the referral process and applicable deadlines regarding detainees who arrive with medication. To ensure quick access to medication, the facility maintains a stock of the most common chronic care medications. In addition, there is a local back up pharmacy, if medication is not readily available on site. Telephone/verbal orders can also be requested by the medical staff to the on-call physician. In addition, detainees arriving with medications are automatically scheduled for a chronic care evaluation within 48 hours of arrival. If a detainee arrives with medication that is in a different language, it is translated to determine if there is a comparable

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medication, and the on-call physician is utilized to determine a comparable medication.

Since January 19, 2016, training curriculum for all employees includes instruction on language line and interpretation services. This is provided during pre-service and in-service training. Additionally, all staff carry on their person a laminated card with instructions on the use of the language line, that they receive upon hire and before being assigned to duty. The card makes it easy for staff to use the language line at any time and from anywhere in the facility, including in intake. In addition, all phones in health services have a sticker on them identifying the language line phone number. Alternatively, the pharmacy vendor CorrectRx is available to assist in identifying comparable medications. These procedures were again discussed by the HSA during the regularly scheduled staff meeting conducted on June 26, 2018.

Effective June 7, 2018, on a weekly basis, the QA nurse reviews a roster of detainee intakes with chronic medical problems and medication. A 5% sample of weekly intakes is reviewed to determine compliance. The staff not in compliance are retrained by the DON or AHSA. The study is reported to the CQI committee on an on-going basis.

Attachment 8:

- E-mail to staff regarding procedure, dated June 29, 2018

Finding: Medical Care, Section (V)(C)(4)(c)

"Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America."

- One of six (16%) detainee records reviewed indicated the patient was not seen by an HIV or infectious disease specialist within 30 days of HIV infection identification.

Plan of Action:

In February 2018, a physician was hired who has an infectious disease fellowship and extensive experience with infectious diseases. To verify this requirement is met, the ICN tracks all newly arrived or newly diagnosed HIV/AIDs patients. As of April 2, 2018, monthly, the ICN reviews 100% of the records HIV/AIDs cases

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to determine if an evaluation by the provider was conducted, a chest x-ray was completed within 72 hours of arrival, and appropriate diagnostic examination and immunizations were completed. The information is provided by the ICN nurse to the QA nurse for every new detainee or newly diagnosed detainee with HIV/AIDs. The QA nurse reports the data to the CQI committee monthly. The review will continue on an on-going basis.

Attachment 9:

- (b)(6); (b)(7)(C) Resume
- HIV Tracking Log

Findings:

Disability Identification, Assessment, and Accommodation; Section (V)(F)(4)(e)

"Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations."

Disability Identification, Assessment, and Accommodation; Section (V)(F)(4)(g)

"After the facility has completed its review of a detainee with a disability or of a request for an accommodation, facility staff shall place written documentation of the following in the detainee's medical and/or detention file…"

- Six (33%) of 20 detainee records reviewed were missing appropriate accommodation orders (special needs). Additionally, the facility does not clearly determine in-record-progress-notes if the provider has assessed the detainees for assistance with activities of daily living.

Plan of Action:

As of May 30, 2018, a specific local procedure was developed to address special needs accommodations. The procedure details identification of special needs, tracking of special needs, notification procedures, a special needs committee, denial/notification of denials, and training of staff.

Effective May 2018, monthly, the patient care coordinator (PCC) and Americans with Disabilities Act coordinator make rounds within the units to determine the status of equipment. The special needs committee meets a minimum of once a

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month to discuss each detainee on the special needs log. As of May 2018, the PCC audits 100% of detainees added to the special needs log to verify provider progress notes and detainee education regarding use of equipment and daily living activities is documented as required. The PCC provides the report to the QA nurse monthly, and the QA nurse reports to the CQI committee each quarter. As of this writing, all grievances have been timely processed.

Attachment 10:

- Special Needs Local Operating Procedure

Finding: Grievance Systems, Section (V)(C)(4)

"Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale. This record shall be maintained per the following section "D. Record-Keeping and File Maintenance."

- Four (11%) of thirty-six grievances were not addressed within 5 working days of receipt.

Plan of Action:

As of June 11, 2018, in each housing unit, specific boxes were labelled "medical grievance" wherein the detainees can submit their medical grievances. The PCC picks up the grievances from the dorms every business day. The grievances are logged in the medical grievance log book. The PCC addresses the grievance within 3 working days and forwards it to the HSA for review. The HSA reviews the grievance within 24 hours, and verifies the response appropriately addresses the grievance. Once approved, the response is returned to detainee by the applicable deadline.

The HSA performs a careful review on each grievance to determine the overall quality of care and timeliness of response. Based on the review, quality of care issues and/or timeliness of response are addressed and discussed with the responsible staff. The information is provided by the PCC and HSA to the QA nurse for trending. Effective May 2018, on a monthly basis, during the regularly scheduled staff meeting, the HSA discusses grievance trends and the findings of the reviews. The data is reported by the QA nurse to the CQI committee monthly. On a weekly basis, the grievance committee meeting is held to discuss all open and

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DHS-ICE-20-0618-A-002074

resolved grievances. Facility leadership are members of this committee. All open and resolved grievances for the week are discussed during this meeting.

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DHS-ICE-20-0618-A-002075

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
08/29/2017	02/01/2017	Adelanto ICE Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,629	1,437	192	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
52	31	21	0	0	48

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)
Address: 10400 Rancho Road Adelanto, CA 82301	Address: 10400 Rancho Road Adelanto, CA 82301

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 4.3.S.4
Sick Call

Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

NCCHC J-A-01 Access To Care

Detainees have access to care to meet their serious medical, dental, and mental health needs. Access to care means that, in a timely manner, a patient can be seen by a clinical provider, be given a professional clinical judgment, and receive care that is ordered.

FINDINGS: Two of ten (20%) of the charts reviewed for urgent care (sick call) did not have timely and appropriate nursing evaluations for the different acute conditions. One detainee was rescheduled for nursing sick call 3 times and another 5 times. Refer to Urgent Care (Sick Call) for additional information.

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One of ten (10%) detainees seen on nursing sick call did not have vital signs documented with the nursing assessment. Refer to Urgent Care (Sick Call) for additional information.

Previous Site Visit 02/01/2017
No deficiencies were noted from the previous site visit.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
438	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
PBNDS 4.3.C.4.
Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

NCCHC J-G-01 Chronic Disease Services

Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
One of six (16%) detainees was not seen by an HIV or ID specialist within 30 days of HIV identification. The detainee was identified as being diagnosed with HIV on September 3, 2016; however, the detainee was not scheduled for ID visit until December 16, 2016.

Two of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification. For one detainee, the diagnosis was identified on July 29, 2017; however, the chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive HIV on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

A review of the facility's chronic care detainees with asthma, hypertension, diabetes and seizure disorder were noted to follow NCCHC and PBNDS standards.

Previous Site Visit 2017:
HIV--Review of 9 charts revealed 8 of 9 (89%) of detainees with HIV had a chest x-ray completed within 72 hours of problem identification.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	10

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were 10 hunger strikes in the last 12 months. One detainee went on hunger strike 6 times, and the other 4 were different detainees. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

Previous Site Visit Findings from 2/1/2017:
There was one reported hunger strike for 2016.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
2	84

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

No deficiencies were noted regarding this section of the standard. The facility currently has 2 cells available for suicide watch. Detainees who are determined to be suicidal are evaluated by a mental health professional and are either placed on suicide watch at the facility or sent out to the local hospital for further evaluation and treatment.

It is noted that in approximately the past 6 months, the facility has had a high number of suicide watches. Many of these detainees are referred to off-site in-patient mental health facilities for the suicide watch due to the lack of available suicide watch space at APC according to CCS leadership. Per CCS leadership, detainees with a suicide attempt are automatically referred to the in-patient mental health facility. There was at least one instance where a detainee was referred to the in-patient facility for a suicide watch when there were cells available on-site for a suicide watch. This case was for a detainee with suicidal ideations without an attempt.

The in-patient mental health facility, Alvarado Parkway Institute (API) is located in San Diego, CA. The facility does not attempt to use more local in-patient mental health facilities within the Los Angeles Field Office. Security services at API are provided by the San Diego ERO Field Office which has concerns regarding the high costs of services provided to Los Angeles detainees.

Previous Site Visit Findings from 2/1/2017:
No deficiencies were noted from the previous site visit.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	3

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were 3 reported deaths in the last 12 months.
--32 year old male died March 28, 2017 at the Victor Valley Hospital. He was found hanging in a restrictive housing unit cell on March 22, 2017. He was admitted to the hospital with the following diagnoses: coma, sever hypoxic encephalopathy, status post full cardiopulmonary arrest, respiratory failure and attempted suicide by self-hanging. Detainee had a history of mental health problems and had recently been hospitalized for his mental health disorder. Final mortality reports are still pending.
--55 year old male died April 14, 2017 at Victor Valley Hospital after being admitted on April 1, 2017 for hemoptysis. He was admitted for work up and treatment for GI bleed, anasarca, sepsis, and leukocytosis. Further workup revealed anemia and cirrhosis of the liver. Esophageal banding was performed on April 4, 2017 and the bleeding stopped. On April 13, 2017, he was being prepared for discharge when he felt dizzy and collapsed in bed. A code blue was called. However, he did not recover from this episode, and he was pronounced dead on April 14, 2017. Final mortality reports are pending.
--46 year old male died May 31, 2017 after collapsing while playing soccer. He was transported to the emergency department where he was pronounced dead. Final mortality reports are pending. The detainee arrived to Adelanto on May 22, 2017 with a significantly high blood pressure and was placed in the infirmary and received a dose of clonidine and was prescribed other blood pressure medications. He was discharged from the infirmary the following day with an order for blood pressure checks, routine labs and an EKG with a follow-up in three to four weeks. Final mortality reports are pending.
The FMCs will address any negative findings from the mortality reports once received.

There are no detainees with terminal illness or detainees with advance directives within the last 12 months. The facility's policy was reviewed, and there were no areas of concern related to the policies.

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Other Observations

The Los Angeles Field Medical Coordinators conducted the IHSC site visit August 29, 2017 through September 1, 2017.

Adelanto ICE Processing Center (APC) is a dedicated IGSA with only ICE detainees. APC operates under The Geo Group Inc. which contracts with CorrectCare Solutions (CCS) to provide on-site medical care. CCS has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 Performance Based National Detention Standards (PBNDS) and is accredited by the National Commission on Correctional Health Care (NCCHC). The facility currently houses approximately 192 female detainees and 1437 male detainees.

APC currently utilizes both paper and electronic medical records. They began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Medication administration, consents, refusals, and some intake screenings are documented on paper records and then scanned into the electronic record.

CURRENT STAFFING:

(b)(7)(E)

Nakamoto Inspection is scheduled for October 3-5, 2017
CRCL follow-up review of medical and mental health care scheduled for November 13-14, 2017

Deficiencies for Areas Evaluated

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The following PBNDS 2011 deficiencies were noted:

PBNDS 4.3.S.4
Sick Call

Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

FINDINGS: Two of ten (20%) of the charts reviewed for urgent care (sick call) did not have timely and appropriate nursing evaluations for the different acute conditions. One detainee was rescheduled for nursing sick call 3 times and another 5 times, which resulted in delay of evaluation and care for 2 weeks for detainees complaining of eye and back pain.

One of ten (10%) detainees seen on nursing sick call did not have vital signs documented with the nursing assessment.

PPBNDS 4.3.C.4.
Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

FINDINGS:
One of six (16%) detainees was not seen by an HIV or ID specialist within 30 days of HIV identification. The detainee was identified as being diagnosed with HIV on September 3, 2016; however, the detainee was not scheduled for ID visit until December 16, 2016.

Two of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification. For one detainee, the diagnosis was identified on July 29, 2017, however chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

Quality of care issues:
Urgent Care (Sick Call):
Eight of ten (80%) of the charts reviewed for urgent care (sick call) had timely and appropriate nursing evaluations for the different acute conditions. The detainee with the complaints of back pain was rescheduled five times before being evaluated. The detainee with the complaints of the eye pain was rescheduled three times before being evaluated. The detainee with the back pain was rescheduled on March 14, March 15, March 16, March 17, March 18 and was eventually evaluated on April 4 during chronic care for the complaint. The detainee with the eye pain was rescheduled on April 16, April 27 and April 28 and was eventually evaluated on April 30. There is no documentation in the medical records regarding why the detainees were rescheduled. According to the HSA, the reschedules could have been due to a variety of factors including provider schedules, medical emergencies, lack of custody to transport the detainee to the clinic, etc. Effective June 2017, the HSA is monitoring the scheduled sick call on a daily basis to review the number scheduled, seen, refused, canceled or rescheduled and the type of complaint for those that were rescheduled if applicable.

Nine of ten (90%) had vital signs documented with the nursing assessment. No vital signs were taken for a detainee complaining of eye pain.

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Evaluation of Care Prior to Emergency Department:

One of ten (10%) charts revealed that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.

In one case, there was a delay in obtaining a laboratory test. The test was ordered on March 18, 2017 however, it was not obtained until April 3, 2017.

Diagnostic Services and Specialty Care Access:

Nine of ten (90%) of the specialty charts reviewed had time urgency documented on the order for specialty care, the appointment was accomplished within the ordered time frame, and the provider acknowledged the specialist's report within 7 days from the performed date of service.

One of the detainees was referred to the ENT on December 29, 2016; the MedPAR was submitted to IHSC on February 21, 2017. There is no documentation in the medical record regarding why there was a delay in submitting the MedPAR. The appointment was completed on March 6, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the ENT appointment. The detainee was released from detention on March 28, 2017.

Three out of four (75%) were evaluated at least every 30 days until the consult was completed. One of the detainees was referred to the OB/GYN on February 13, 2017, and the appointment was on March 7, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the GYN appointment.

Diabetes:
Five of six (90%) of detainees had aspirin prescribed, as clinically indicated. In one instance aspirin was not prescribed as indicated for a 55 year old detainee with hyperlipidemia, hypertension, and positive family history.

Previous Site Visit Deficiencies from 2/1/2017:

HIV--Review of 9 charts revealed 8 of 9 (89%) of detainees with HIV had a chest x-ray completed withing 72 hours of problem identification. Detainee did not disclose his HIV status upon intake or during his physical. Once he did disclose his HIV status, medications, labs and follow-up was ordered; however, the chest x-ray was not completed.

Previous Site Visit Quality of Care Issues identified from 2/1/2017:

9 of 10 (90%) charts reviewed revealed a nursing referral was submitted within 24 hours where appropriate. Detainee was assessed during sick call and found to have a fever (100.4) and heart rate of 107. The nurse treated the detainee using nursing protocols and unable to locate nursing protocol in medical record.

9 of 10 (90%) charts reviewed revealed the assessment reflecting the hospital findings and concurrence or reason for deviation from the hospital recommendations.
Detainee released from the hospital with recommendations for a neurology follow-up in 3-4 weeks. Recommendations were not addressed timely.

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. Documents were not scanned into the appropriate section of the medical record consistently. For example consult notes were scanned into the consent section.

One chart had medications listed on the MAR but unable to find orders for medications.

Lab was ordered to be drawn on 8/24/16 and were not drawn. A refusal was obtained and placed

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in the chart on 8/30/16.

5 of 6 (83%) charts reviewed revealed the detainee was re-assessed by the provider at least every 30 days until the off-site service was completed.

6 of 7 (85%) charts reviewed the clinician acknowledged the specialist's report within seven days after the service was performed.

6 of 7 (86%) of charts reviewed revealed treatment plans were updated every 90 days. Although each detainee chart reviewed did have complete assessment, treatment plan and follow-up plan documented, the formal mental health treatment plan was not completed on each detainee. The formal mental health treatment plan is one which includes identification of strengths, weakness, treatment goals and interventions.

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Suicide Screening

Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of detainees had an indication for a mental health referral were referred appropriately and evaluated timely. They were evaluated by a qualified mental health provider daily while on suicide watch with appropriate monitoring and consistent documentation. No issues were identified.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

Health Assessment

Twenty charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

20 of 20 (100%) of charts reviewed had an initial screen completed within 12 hours of booking.

18 of 18 (100%) had tuberculosis screening completed as per CDC guidelines. Two of the detainees had a chest x-ray completed at the transferring facility.

11 of 11 (100%) of detainees who screened positive for mental health or suicide risk were referred for an evaluation. The other 9 detainees did not have a positive mental health screen.

20 of 20 (100%) of those identified with an acute or chronic condition during intake screening had timely follow-up for their significant findings and a complete health evaluation within 14 days of intake.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

Urgent Care (Sick Call)

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Eight of ten (80%) of the charts reviewed for urgent care (sick call) had timely and appropriate nursing evaluations for the different acute conditions. The detainee with the complaints of back pain was rescheduled five times before being evaluated. The detainee with the complaints of the eye pain was rescheduled three times before being evaluated. The detainee with the back pain was rescheduled on March 14, March 15, March 16, March 17, March 18 and was eventually evaluated on April 4 during chronic care for the complaint. The detainee with the eye pain was rescheduled on April 16, April 27 and April 28 and was eventually evaluated on April 30. There is no documentation in the medical records regarding why the detainees were rescheduled. According to the HSA, the reschedules could have been due to a variety of factors including provider schedules, medical emergencies, lack of custody to transport the detainee to the clinic, etc. Effective June 2017, the HSA is monitoring the scheduled sick call on a daily basis to review the number scheduled, seen, refused, canceled or rescheduled and the type of complaint for those that were rescheduled if applicable.

Ten of ten (100%) of care was delivered within the scope of the nurse's license.

Nine of ten (90%) had vital signs documented with the nursing assessment. No vital signs were taken for a detainee complaining of eye pain.

Six of six (100%) had a nursing referral to a nurse practitioner submitted within 24 hours.

Six of six (100%) of the detainees who were referred to a provider had an assessment and treatment plan documented by the nurse practitioner.

Previous Site Visit Findings from 2/1/2017:

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10 charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.
9 of 10 (90%) reviewed revealed a nursing referral was submitted within 24 hours where appropriate. Detainee was assessed during sick call and found to have a fever (100.4) and heart rate of 107. The nurse treated the detainee using nursing protocols.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees had an outbound progress note and an inbound assessment, as well as an assessment that reflected hospital findings and concurrence or reason for deviation from the hospital recommendations. Detainees were also found to have discharge documentation from the hospital or emergency department (ED) in the chart.

Nine out of ten (90%) charts revealed no evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.

In one case, there was a delay in obtaining initial routine blood work after history and physical which included a complete metabolic panel. Test was ordered on March 18, 2017 and was not collected until April 3, 2017. Detainee was sent to the emergency room for hyperglycemia on April 5, 2017.

Previous Site Visit findings from 2/1/2017:
9 of 10 (90%) charts reviewed revealed the assessment reflect the hospital findings and concurrence or reason for deviation from the hospital recommendations.
Detainee released from the hospital with recommendations for a neurology follow-up in 3-4 weeks. Recommendations were not addressed timely.

Medication Administration Practices

Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Two of two (100%) of detainees had documentation in the medical record that the prescribing physician was notified of consecutive refusals. No issues were identified.

Two out of two (100%) detainees had an appropriate response from the clinician (i.e was the patient was interviewed or the prescription was changed or discontinued. No issues were identified.

The facility has a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up.

Approximately 3% of MARs reviewed had either blanks, consecutive refusals, or no shows.

All previous month MARs were filed in the detainee medical records.

Approximately 70% of patients are on self-administered medications.

Over the counter (OTC) medications are provided by medical and the commissary.

Previous Site Visit Findings from 2/1/2017:
No findings were noted from the previous site visit.

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Continuity of Medication

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of detainees had medications ordered less than 24 hours from completion of intake screening, and received their first dose in less than 24 hours from the order. No issues were identified.

Previous Site Visit Findings from 2/1/2017:
No findings were noted from the previous site visit.

Mental Health Screen

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a positive screen for mental illness or suicide risk and were referred for evaluation by a mental health provider in a timely manner.

Previous Site Visit Findings from 2/1/2017:
No issues were identified.

Medical Recordkeeping Practices

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. APC utilizes both paper and electronic medical records. They began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Medication administration, consents, refusals, and some intake screenings are documented on paper records and then scanned into the electronic record.

Ten of ten (100%) revealed that the medical recordkeeping practices are in compliance or non-applicable.

Previous Site Visit Findings from 2/1/2017:

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. Documents were not scanned into the appropriate section of the medical record consistently. For example consult notes were scanned into the consent section.

One chart had medications listed on the MAR but unable to find orders for medications.

Pregnant Women

Two charts were reviewed using the IHSC Quality of Care Audit Tool as there were only two pregnant detainees within the last 6 months at the facility.

APC performs pregnancy tests on all females aged 10-54 during intake screening, prior to x-ray or initiation of medications.

Two of two (100%) had an OB/GYN consult ordered within 7 days of pregnancy confirmation and were seen within 30 days.

Two of two (100%) were screened for HIV, STI, and viral hepatitis and prescribed prenatal vitamins.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

Dental Care

Ten charts were reviewed using the IHSC Quality of Care audit tools to evaluate this area.

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Ten of ten (100%) of charts reviewed found all were screened for symptoms during the intake process, and two were referred to the dental provider and evaluated within 48 hours. The dental clinical notes described findings, diagnosis and treatment plans. No issues were identified.

Previous Site Visit Findings from 2/1/2017:
No findings were noted from the previous site visit.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. Ten of ten (100%) of the patients had laboratory testing done within one business day of the ordered date or by the due date.

Ten of ten (100%) of the patients who had labs drawn, routine results were back within 7 days and acute results were back in 24 hours; the results were acknowledged by a clinician with an appropriate response.

Previous Site Visit Findings from 2/1/2017:
Eight charts reviewed with lab orders using the IHSC Quality of Care Audit Tool

7 of 8 (88%) lab orders reviewed were found to have been drawn within 1 business day of the order or within the time frame ordered. The results were back within 24 hours. The lab results were clinically acknowledged with the appropriate response. The results were discussed with the detainee at a follow-up appointment.

Lab was ordered to be drawn on 8/24/16 but was not drawn. A refusal was obtained and placed in the chart on 8/30/16.

Diagnostic Services and Specialty Care Access

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Nine of ten (90%) of the specialty charts reviewed had time urgency documented on the order for specialty care and the appointment was accomplished within the ordered time frame.

Three out of four (75%) were evaluated at least every 30 days until the consult was completed.

One of the detainees was referred to the ENT on December 29, 2016; the MedPAR was submitted to IHSC on February 21, 2017. There was no documentation in the medical record regarding why there was a delay in submitting the MedPAR. The appointment was completed on March 6, 2017; however, the detainee was not re-evaluated every 30 days and there was no follow-up by the provider after the appointment. The consultation was normal and acknowledged by the provider, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the ENT appointment. The detainee was released from detention on March 28, 2017.

Nine of ten (90%) of the specialty charts reviewed revealed that the provider acknowledged the specialist's report within 7 days from the performed date of service.

One of the detainees was referred to the OB/GYN on February 13, 2017, and the appointment was on March 7, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the GYN appointment.

Previous Site Visit Findings from 2/1/2017:
10 charts were reviewed using the IHSC Quality of Care Audit Tool
5 of 6 (83%) charts reviewed revealed the detainee was re-assessed by the provider at least every 30 days until the off-site service was completed.
6 of 7 (85%) charts reviewed showed the clinician acknowledged the specialist's report within seven days after the service was performed.

Mental Health Treatment Planning

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees had a clinical assessment, treatment, and follow-up plan documented. No issues were identified.

Nine out of nine (100%) of detainees had treatment plans updated at a minimum of every 90

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days. No issues were identified.

Previous Site Visit Findings from 2/1/2017:

6 of 7 (86%) of charts reviewed revealed treatment plans were updated every 90 days. Although each detainee chart reviewed did have complete assessment, treatment plan and follow-up plan documented, the formal mental health treatment plan was not completed on each detainee. The formal mental health treatment plan is one which includes identification of strengths, weakness, treatment goals and interventions.

Treatment of Disability

Ten charts was reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) had the disability noted in the file, the detainees was assessed for assistance with activities of daily living (ADL), and appropriate accommodations were ordered. The detainees did not require assistance with ADL's.

The facility maintains a current list of detainee with disabilities.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

Complaints and Grievances

Grievance logs were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. 40 grievances were submitted over the past three months. All were appropriately addressed within five working days. No issues or trends were identified during the current site visit. There were a total of six grievances due to availability of care; twelve due to denial or refusal of specific request for care; nine due to delay of care; one due to competency/ professional skillset of medical staff; two due to attitude, demeanor or conduct or staff, and 10 due to various other issues such as requesting personal property, being exposed to quarantine by sharing the recreation yard, etc.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

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Diabetes

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

The facility uses the BOP Diabetes Clinical Practice Guidelines.

Seven out of seven (100%) of detainees had blood sugar measured and recorded on intake. No issues were identified.

Ten out of ten (100%) of detainees were seen for chronic care within seven days of illness identification, had lipids measured within one year, and were followed at least every 90 days with appropriate vital signs. No issues were found.

Nine of nine (100%) of detainees had a baseline HgbA1c performed within 30 days of intake or within the past 3 months. No issues were found.

Five of six (90%) of detainees had aspirin prescribed, as clinically indicated.

In one instance aspirin was not prescribed as indicated for a 55 year old detainee with hyperlipidemia, hypertension, and positive family history.

Eight out of eight (100%) of detainees had the degree of control (goal HgbA1C <7) documented. No issues were identified.

Four of four (100%) of detainees had a strategy to attain diabetes control documented if HgbA1C was above goal. No issues were identified.

Previous Site Visit Findings from 2/1/2017:
No deficiencies were noted from the previous site visit.

Human Immunodeficiency Virus (HIV)

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Five out of six (83%) of detainees were seen by an HIV or ID specialist within 30 days of HIV identification. In one instance, the detainee was identified as being HIV positive on September 3, 2016 and was not scheduled for a chronic care clinic (CCC) ID visit until December 16, 2016.

Eight out of eight (100%) of detainees had a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months. No issues were found.

Nine out of nine (100%) of detainees had anti-retroviral treatment considered and documented. No issues were found.

Four out of four (100%) of detainees were seen by a mid-level provider or physician for chronic care at least every 90 days. No issues were found.

Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainees was identified on July 29, 2017; however, the chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage HIV detainees.

Previous Site Visit Findings from 2/1/2017:
Nine charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
8 of 9 (89%) charts reviewed revealed a chest x-ray was completed within 72 hours of problem identification.

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One detainee did not reveal his HIV status upon intake or physical assessment. Once identified, labs were ordered and appropriate follow-up however; a chest x-ray was not ordered.
Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage HIV detainees.

Hypertension

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had documented blood pressure reading at intake and were seen by an MD/PA/NP within 14 days of illness identification.

Five of five (100%) were noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.

Ten of ten (100%) were followed using the facility's local hypertension guideline that included baseline laboratory testing.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with hypertension.

Previous Site Visit Findings from 2/1/2017:
There were no findings from the previous site visit.

Asthma

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Nine out of nine (100%) of detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification and had a peak flow completed at the initial physical exam. No issues were identified.

Eight out of nine (89%) of detainees had a peak flow completed at the initial exam. One detainee did not report asthma on intake however the medical transfer summary received by Adelanto noted a history of chronic asthma, therefore a peak flow should have been performed.

Ten out of ten (100%) of detainees had a peak flow completed at the CC visit or within the last 3 months. No issues were identified.

Ten out of ten (100%) of detainees had a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with asthma.

Previous Site Visit Findings from 2/1/2017:
No deficiencies were noted from the previous site visit.

Seizure Disorder

Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) detainees had appropriate neurological history completed at the initial physical examination. No issues were identified.

Ten out of ten (100%) detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification. No issues were identified.

Six out of six (100%) detainees had serum drug levels performed and acknowledged in the medical record every three months until stable, then every six months where indicated. No issues were identified.

Eight out of eight (100%) detainees had a treatment plan established. No issues were

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identified.

Ten out of ten (100%) detainees had orders for a bottom bunk. No issues were identified.

Adelanto uses no clinical practice guidelines to manage detainees with seizure disorders.

Previous Site Visit Findings from 2/1/2017:
No deficiencies were noted from the previous site visit.

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Recommendations

(b)(5)

Facility Actions

The Quality Improvement Committee is conducting several studies related to medical complaints and CAPs to ensure compliance. The information is shared with the FMC quarterly.

Effective June 2017, the Health Services Administrator is monitoring sick call daily to ensure detainees are seen as scheduled and not rescheduled.

The Health Services Administrator reports and educates staff regarding the different medical complaints and site visit findings.

The Health Services Administrator provides training and refresher training to clinical staff regarding the management of detainees with chronic and acute conditions.

Additional Comments

The following CAPs were updated during the site visit:

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1. FMC Site Visit - February 2017 - Items still open.
2. ODO Preliminary Findings July 17, 2017 - All items completed
3. Medical Complaint (b)(6); (b)(7)(C) - All items completed
4. Medical Complaint (b)(6); (b)(7)(C) - Items still open. After the site visit, the CAP was revised after CRCL reviewed the initial CAP responses and provided additional recommendations. Responses are pending.
5. Medical Complaint (b)(6); (b)(7)(C) - All items completed
6. Medical Complaint - All items completed
7. Medical Complaint All items completed

Update regarding the Corrective Action Plan in response to the CRCL 2015 Site Visit:

1. ERO, IHSC and ADF must audit all Special Management Unit (SMU) cases to identity those detainees housed in the SMU, partially or wholly due to mental health conditions and, develop a housing alternative that includes necessary and consistently delivered mental health services.
-Completed. As recommended by the CRCL Psychiatrist, a review of all detainees in the SMU were completed as of December 31, 2015. The identified detainees were transferred out of the Adelanto Detention Facility (ADF).

2. The Mental Health Director and IHSC must ensure that ADF mental health staff conduct daily face-to-face rounds with all detainees in the SMU and provide appropriate mental health assessments and treatment.
-Current practice. Beginning in April 2016, a dedicated Registered Nurse was assigned to conduct daily Medical and Mental Health rounds to include Sick Call and welfare checks for all detainees in SMU. Beginning August 12, 2016, Mental Health staff began conducting weekly mental health groups with Administrative Segregation detainees. Anger Management was started on August 12, 2016. Positive Coping Skills groups were started on August 10, 2016 and September 15, 2016. On September 7, 2016, psychologists began conducting daily Mental Health visits to all detainees housed in Special Management Units. The previous FMC witnessed these rounds and group sessions being conducted.

3. The Mental Health Director, ERO, and IHSC must ensure that custody staff cease determining or influencing whether or not a detainee requires medical or mental health services.
-Current practice. All staff are reminded during daily briefings that detainees are to be provided access to medical and mental health care staff as requested or needed. Only medical or mental health staff may determine if a detainee will or will not be seen. Custody staff assigned to SMU receive 40 hours of specialized training which includes four hours of medical response and awareness training. As of November 13, 2017, training log sign in sheet received by the FMC.

4. ICE must audit all detainees held in the SMU over 30 days for protective housing reasons, and determine if transfer to another facility is more appropriate.
-Completed. An audit was performed and detainees were transferred out. The previous FMC had first hand knowledge of this being completed. This continues to be current practice.

5. ERO must conduct an external audit of all detainees held in Administrative and Disciplinary Segregation over 30 days to determine if transfer to another facility could improve treatment or resolve use of the SMU for special housing.
-Current practice. All cases in Administrative and Disciplinary Segregation held over 30 days were reviewed at the onset of this request and the process continues on a weekly basis. All Administrative and Disciplinary Segregation cases are reviewed on a weekly basis by a multi-disciplinary panel to determine if continued detention in either Administrative or Disciplinary Segregation is warranted or beneficial. In addition, consideration is given to transfer to another facility or release from custody for long term cases. Documentation of SMU housing reports and weekly SMU minutes received by FMC.

6.GEO and ICE (IHSC) must conduct an audit of all medical files, starting with the detainee Chronic Care List, and take action to ensure all detainees receiving medical/mental health care are current on appointments (on-site and off-site), treatments (including surgeries},

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and are receiving the appropriate and timely assessments and treatments for their conditions.
-Completed. The full audits were completed in the East by January 1, 2016 and completed in the West by January 29, 2016. Audits conducted prior to responsibility being assumed February 1, 2016 by Correct Care Solutions. Supporting documentation unavailable from GEO corporate or Regional Managers per the HSA.

7. The paper-based medical record must be changed to include a separate section for medical orders (with a standard order form).
-Completed. GEO policy 303/303-A addresses the chart order and organization. The process of adding a separate section or page for medical orders has been used before and can lead to errors in the duplicate writing. To address the issue of incomplete order notations, a brightly colored sheet to note orders needing attention will enhance the facility's current system. Quality Control nurses will review files before refilling to confirm that all physician notes have been handled properly. An EHR system was implemented August 16, 2016. Detainees housed prior to August 16, 2016 and still remaining at ADF will have a hybrid record (paper record until August 15, 2016 and electronic records from August 16, 2016). The FMC had first hand knowledge of completion.

(b)(6); (b)(7)(C); (b)(7)(E)

9. The medical record must be standardized. Only forms approved by the Clinical Director and the Medical Record Director should be used for charting.
-Completed. On December 21-22, 2015, the Medical Records Supervisor conducted an In-Service Training with the medical records staff to review the policy requirements under the Contents and Format in Health Records, Policy Number 303 and 303-A, dated May 9, 2014. On December 29, 2015, an In-Service Training for all health care providers will be conducted, addressing the use of approved standard GEO Forms. GEO policy Contents and Format in Health Records, Policy Number 303 and 303-A, dated May 9, 2014, addresses the order and organization of the medical records. The health care provider will be using only current approved GEO Forms. Training December 22, 2015 and January 12, 2016. December 22, 2015 sign in sheet was obtained. January 12, 2016 training log unavailable. Correct Care Solutions assumed responsibility February 1, 2016 with different policies and forms. Training log sign in sheet for those policies and forms received by the FMC.

10. GEO must draft a Request for Proposals (RFP) in order to begin the process of selecting, procuring and deploying an Electronic Health Record (EHR) that is appropriate for detention health care. (Deploy the EHR within twelve months.)
-Completed. Electronic Health Record system was implemented August 16, 2016.

11. ICE HQ must immediately require a CAP be developed for all issues identified during the on-site investigation and, within 90 days, all local and headquarters CAP items must be fully corrected, and documented; signed by ICE and GEO headquarters.
-As of October 12, 2017, the CAP is still in progress. All medical and mental health related items on the CAP are addressed here to provide updates.

12. GEO and ICE (IHSC) must audit the medical files of detainees on the Mental Health Chronic Care List, prioritizing detainees who are in Segregation, and take action to ensure that all detainees are receiving appropriate mental health care. In particular, ensuring that

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detainees with psychotic disorders are diagnosed as such and are offered adequate antipsychotic medication, including long-acting injectable antipsychotics, especially when medication in-adherence is present.
-Completed January 20, 2016. The FMC had first hand knowledge of this being completed.

13. ACF Mental Health staff must follow GEO Procedure 623-A, which calls for a complete "Written comprehensive Initial Psychiatric Evaluation (Form HS-906) that "will address current and past inpatient and outpatient psychiatric treatment and psychotropic medications." Moreover, Mental Health Staff must demonstrate an attempt to obtain collateral historical information (and not simply indicate that a detainee has refused). If such information is available in a transfer summary, that must be placed in the chart and referenced by the mental health provider. This procedure should be done retrospectively for all detainees on the Mental Health Chronic Care List who are in segregation.
-Completed January 20, 2016. Documentation from previous GEO training unavailable. Correct Care Solutions assumed responsibility February 1, 2016 with different policies and forms. Training log sign in sheet for those policies and forms received by the FMC.

14. Detainees needing emergent transport and admission to outside acute psychiatric inpatient units should wait no more than 72 hours after such a determination/request before transfer is made by a mental health clinician. Relationships with potential accepting institutions must be established and/or strengthened in order to address this need.
-Completed. A contract with Alvarado Parkway Institute for acute needs has resolved this issue. The contract was signed in October 2015. Adelanto currently utilizes API for in-patient mental health services.

15. The paper-based medical record must be changed to include a separate section for medical orders (with a standard order form).
-Completed. To address the issue of incomplete order notations, the facility's current system will be enhanced by a brightly colored sheet to note orders needing attention. Quality Control nurses will review files before refilling to confirm that all physician notes have been handled properly. The FMC had first hand knowledge of this being completed.

(b)(6); (b)(7)(C); (b)(7)(E)

17. The medical record must be standardized. Only forms approved by the Clinical Director and the medical record director should be used for charting.
-Completed. The medical records staff was re-trained to file the records in the proper section and in reverse chronological order as per GEO policy. As of January 8, 2016, the training of staff was being conducted on use of only GEO approved forms. Previous GEO training forms unavailable. Correct Care solutions assumed responsibility February 1, 2016. Electronic health record system has resolved this issue.

18. GEO must draft a Request for Proposals (RFP) in order to begin the process of selecting, procuring and deploying an Electronic Health Record appropriate for detention health care.
-Completed January 20, 2016. The Electronic Health Record system was implemented August 16, 2016.

19. All mental health staff must have access to GEO Track, where they can review and change their own appointments and those of other mental health clinicians. Each clinician should have his/her own schedule.
-Completed. Training was provided by Correctional Health Services Director on December 30, 2015, and December 31, 2015. Training log unavailable as this was conducted by GEO corporate staff prior to responsibility being assumed by Correct Care Solutions on February 1, 2016. However, Adelanto no longer uses GEO track to schedule patient visits as they now have the electronic health records system.

Recommendation Only

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(b)(5)

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 815-(b)(6); (b)(7)(C)	Date Prepared: 09/25/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 10/11/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved: 11/24/2017
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Unit Chief, MCM
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 11/24/2017

Recommendations:

1. FMC to share approved report with the field office.
2. FMC to request a corrective action plan (CAP) to address the PBNDS 2011 deficiencies and quality of care issues. CAP is due in 30 days.
3. Both Los Angeles FMCs, possible 3rd FMC as well, to conduct another site visit within 30 days of receipt of approved CAP; review additional records for standards compliance and quality of care tools.

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
12/02/2019	05/20/2019	Adelanto ICE Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,550	1,288	262	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
17	8	9	0		10

Facility Administration

Health Services Administrator	Clinical Director
Name: Vacant	Name: (b)(6); (b)(7)(C)
Email:	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)
Address: 10400 Rancho road Adelanto, CA 82301	Address: 10400 Rancho road Adelanto, CA 82301

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

REPEAT FINDING

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Three of ten (30%) detainees were not assessed for assistance with activities of daily living (ADL), and appropriate accommodations ordered. The facility does not clearly determine in the progress notes if the provider has assessed the detainees for assistance with activities of daily living. A#s: (b)(6); (b)(7)(C)

Previous Site Visit 05/20/2019 FMC Site Visit

PBNDS 4.3.U.5
Delivery of Medication
Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications.

FINDINGS:

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Two of ten (20%) of the charts reviewed indicated that patients did not receive their first dose of medication in less than 24 hours from arrival to the facility. Two received their first dose of medication in 48 hours.

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Ten detainees were assessed for assistance with activities of daily living (ADL), and appropriate accommodations ordered. The facility does not clearly determine in the progress notes if the provider has assessed the detainees for assistance with activities of daily living.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
295	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No deficiencies noted.

Previous findings from 05/20/2019 FMC Site Visit
PBNDS 4.3.M
Comprehensive Health Assessment

Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition. Physical examinations shall be performed by a physician, physician assistant, nurse practitioner, RN (with documented training provided by a physician) or other health care practitioner as permitted by law.

FINDINGS:
Two out of ten (20%) detainees were not seen in Chronic Care Clinic by an advanced practice provider or physician within 14 days of asthma identification. One detainee was seen on the 15th day and another on the 22nd day.

PBNDS 4.3.C.4.
Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

NCCHC J-G-01 Chronic Disease Services

Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
Two out of nine (22%) of detainees were not seen by an ID specialist within 30 days of HIV identification or arrival at the facility. One of the detainees arrived on March 8, 2019 and was scheduled to see ID. The ID's office rescheduled the appointment. The detainee was seen on May 24, 2019. One detainee arrived to the facility on September 28, 2018 and was seen by

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ID on December 5, 2018.

PBNDS 4.3.AA.7
Informed Consent and Involuntary Treatment
If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment.

FINDINGS:
Two out of eight (25%) detainees with a history of seizures, did not have a serum drug level performed and acknowledged in the medical record every 3 months. Two of the detainees refused labs initially and the labs were rescheduled. One detainee arrived November 12, 2018; the lab was refused on March 7, 2019; lab reordered for June 12, 2019. Another detainee arrived October 31, 2019; refused labs May 14, 2019; labs reordered for June 11, 2019. There was no documentation that reasonable efforts were made to explain the necessity for the recommended labs.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were a total of 5 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

Previous findings from 05/20/2019 FMC Site Visit
There were a total of 5 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
1	204

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There was one suicide watch at the time of the site visit. No deficiencies were noted regarding this standard. Detainees who are determined to be suicidal are evaluated by a mental health provider and are either placed on a constant or staggered (15 minute checks) suicide watch at the facility. Detainees on suicide watch are evaluated by a mental health provider daily. The facility has 2 cells available for suicide watch. If the cells are occupied or if a serious suicide attempt is made, the detainee is sent out to the local hospital for further evaluation and treatment.

The facility continues to use Anaheim Global Medical Center (AGMC) as the primary mental health facility. If no beds are available then other local hospitals in the area are utilized.

Previous findings from 05/20/2019 FMC Site Visit

There were no deficiencies noted regarding this section of the standard.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Previous findings from 05/20/2019 FMC Site Visit
There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Other Observations

The Adelanto ICE Processing Center (AIPC) IHSC Site visit was conducted December 2, 2019 through December 6, 2019. The site visit was completed by (b)(6); (b)(7)(C) the Los Angeles Field Medical Coordinators. A total of 198 records were reviewed during the site visit.

AIPC is a dedicated IGSA with only ICE detainees. The facility currently houses approximately 262 female detainees and 1288 male detainees. AIPC operates under The Geo Group Inc. which contracts with Wellpath, formally known as Correct Care Solutions (CCS) to provide on-site medical care. Wellpath has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 Performance Based National Detention Standards (PBNDS). AIPC has had several audits to include American Correctional Association (ACA) Accreditation in October 2019; Nakamoto Annual Audit November 19-21, 2019; NCCHC February 11-13, 2019; and ODO inspection March 12-14, 2019. Disability Rights California (DRC) visit is scheduled for January 24, 2020

AIPC utilizes both paper and electronic medical records. AIPC began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Documentation prior to August 30, 2016 remains on paper and is scanned into eCW. Consents and refusals are paper records and are scanned into the electronic record. Effective February 19, 2019, AIPC began utilizing an electronic medication administration record, sMARt. However, eCW and sMARt do not interface.

AIPC has had several administrative changes. Since the retiring of the Health Services Administrator (HSA) on August 31, 2018, there have been four succeeding HSA's. The first HSA started on September 4, 2018. On January 15, 2019, the HSA went on Family and Medical Leave and did not return to the facility. The term for the second HSA was April 1, 2019 - May 15,

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2019. During the interim periods, the Assistant Health Services Administrator (AHSA) was the Acting HSA. On May 13, 2019, the AHSA resigned. On May 28, 2019, Wellpath's Regional Director of Compliance assumed the Acting HSA position. On August 2019, the fourth HSA assumed the role of acting. Wellpath has selected a new HSA; however, background clearance is pending. The Wellpath staffing is currently at 86.05% with 86.33% supplemental Wellpath funded staff.

Deficiencies for Areas Evaluated

PBNDS 2011:

See Medical Care Deficiency above.

QUALITY OF CARE:

Human Immunodeficiency Virus (HIV):

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
Seven out of nine (22%) of detainees were not seen by an ID specialist within 30 days of HIV identification or arrival at the facility. Two of the detainees were identified in the previous FMC Site Visit Report. One of the detainees arrived on March 8, 2019 and was seen by the ID on May 24, 2019. One detainee arrived to the facility on September 28, 2018 and was seen by ID on December 5, 2018. One detainee arrived August 28, 2019 and was seen by the ID on October 18, 2019. Another detainee arrived May 13, 2019 and was seen by the ID on June 21, 2019. Another detainee arrived September 28, 2019 and was seen by the ID on December 5, 2018. Three detainees arrived on October 17, 2019, October 28, 2019 and October 30, 2019, all were pending to be seen by the ID.

MEDICATION ADMINISTRATION RECORDS (MAR):
FINDINGS:
MARs are not being scanned into eCW. The facility has advised that the sMARt and eCW are not interfaced. MARs are only available in the sMARt system.

DIABETES:
FINDINGS:
One out of ten (10%) detainees with diabetes did not have a blood sugar measures and recorded at intake.

SEIZURE:
FINDINGS:
One out of ten (10%) detainees with a history of seizures did not have a bottom bunk order in the medical record. The provider mentioned low bunk/low tier in the note however, a chrono was not issued.

HEALTH ASSESSMENT:
FINDINGS:
One out of fifteen (7%) detainees refused a PPD on intake. A chest x-ray was ordered however, never obtained.

LABORATORY TESTING:
FINDINGS:
One out of ten (10%) detainees who had labs performed, was not advised of the results.

SUICIDE SCREENING:
FINDINGS:
One out of ten (10%) detainees who were on monitoring, did not have checks documented consistently. The checks were ordered for every 15 minutes. Some checks were up to every 18

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minutes.

TREATMENT OF DISABILITY
One out of ten (10%) detainees did not have the disability prominently noted in the file. The detainee was deaf in the right ear and the problem list was not updated to include the disability.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QCM Tool

Health Assessment

See QCM Tool

Urgent Care (Sick Call)

See QCM Tool

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QCM Tool

Medication Administration Practices

See QCM Tool

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Continuity of Medication

See QCM Tool

Mental Health Screen

See QCM Tool

Medical Recordkeeping Practices

See QCM Tool

Pregnant Women

See QCM Tool

Dental Care

See QCM Tool

AMERICAN OVERSIGHT

Acute Laboratory Testing

See QCM Tool

Diagnostic Services and Specialty Care Access

See QCM Tool

Mental Health Treatment Planning

See QCM Tool

Treatment of Disability

See QCM Tool

Complaints and Grievances

See QCM Tool

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QCM Tool

Human Immunodeficiency Virus (HIV)

See QCM Tool

Hypertension

See QCM Tool

Asthma

See QCM Tool

Seizure Disorder

See QCM Tool

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Recommendations

(b)(5)

Facility Actions

(b)(7)(E)

4) The Medical Director has instructed the providers to assess need for assistance with ADLs in detainees with disabilities. The Medical Grievance Coordinator will begin monitoring to ensure compliance.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
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Phone Number: +1 (202) 809-(b)(6); (b)(7)(C)	Date Prepared: 03/06/2020
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IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 03/20/2020

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
02/01/2017	05/10/2016	Adelanto Detention Facility

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,844	1,557	287	0	3

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
65	36	29	0	6	31

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)
Address: 10400 Rancho road Adelanto, CA 82301	Address: 10400 Rancho road Adelanto, CA 82301

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Previous Site Visit 05/10/2016
PBNDS 2011 Any detainee referred for mental health treatment as indicated but no later than 72 hours after the referral or sooner if necessary. No issues found during current site vist.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
292	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facilities chronic care detainees with asthma, hypertension, diabetes and seizure disorder were noted to follow NCCHC and PBNDS standards.

PBNDS 4.3.C.4.
Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

HIV--Review of 9 charts revealed 8 of 9 (89%) of detainees with HIV had a chest x-ray completed within 72 hours of problem identification.

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Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There was one reported hunger strike for 2016. Review of facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
2	

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Previous deficiency from May 10, 2016 site visit
PBNDS (2011) 4.6 F.4
All detainees discharged from suicide watch should be re-assessed by an appropriately trained and qualified medical staff member at intervals consistent with the level of acuity.
No deficiencies were noted during the current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit tool.
No issues were found.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

The Los Angeles Field Medical Coordinator conducted the site visit January 30 through February 3, 2017. A total of 196 charts were reviewed.

Adelanto Detention Facility (ADF) is a dedicated IGSA with only ICE detainees. ADF operates under The Geo Group Inc. which contracts with CorrectCare Solutions (CCS) to provide on-site medical care. CCS has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 Performance Based National Detention Standards (PBNDS) and recently received their initial accreditation on April 10, 2016 for 2014 National Commission on Correctional Health Care (NCCHC). The facility currently houses approximately 287 female detainees and 1557 male detainees.

ADF currently utilizes both paper and electronic medical records. ADF began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Documentation prior to August 30, 2016 remains on paper and documentation following August 30, 2016 is electronic. Medication administration, consents, and refusals are paper records and scanned into the electronic record.

CURRENT STAFFING:

(b)(7)(E)

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(b)(7)(E)

Deficiencies for Areas Evaluated

Previous findings:
One detainee was released to general population following being placed on suicide watch on March 21, 2016 and not seen by a mental health provider until April 24, 2016. No issues identified for current site visit.

One detainee was seen by a registered nurse for sick call on February 14, 2016 for stress but was not seen by a mental health provider until February 24, 2016. No issues identified for current site visit.

Issues identified from current site visit;

HIV--Review of 9 charts revealed 8 of 9 (89%) of detainees with HIV had a chest x-ray completed withing 72 hours of problem identification. Detainee did not disclose his HIV status upon intake or during his physical. Once he did disclose his HIV status, medications, labs and follow-up was ordered however; chest x-ray was not completed.

Quality of care issues identified
Previous finding:
18 of 19 (95%) of charts reviewed for detainees with diabetes had a blood sugar measured and recorded on intake. No issues noted

14 of 16 (88%) of charts reviewed for detainees with asthma had a peak flow at the initial physical exam. Two detainees did not have a peak flow documented. No issues noted

11 of 12 (92%) of charts reviewed for detainees with a seizure disorder had an order for lower bunk. No issues noted

51 of 52 (98%) charts reviewed had a complete evaluation within 14 days, however one did not have vital signs documented during their physical assessment and two others did not have vital documented during their intake screening. No issues noted

12 of 13 (93%) of charts reviewed had the facility's provider acknowledge reports from outside consultants within seven days of the outside appointment. This was identified as an issue during current site visit. (SEE BELOW)

14 of 15 (93%) of charts reviewed had an inbound assessment when returning from outside hospital. No issues noted

19 of 20 (95%)of charts reviewed from the mental health caseload had a mental health clinical assessment, treatment, and follow-up plan documented. No issues were noted for detainees with

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chronic mental health problems. All charts reviewed found appropriate assessment, treatment and follow-up plan documented however; the formal treatment plan was not completed timely.

Quality of care issues identified during current site visit:

9 of 10 (90%) charts reviewed revealed a nursing referral was submitted within 24 hours where appropriate. Detainee was assessed during sick call and found to have a fever (100.4) and heart rate of 107. The nurse treated the detainee using nursing protocols and unable to locate nursing protocol in medical record.

9 of 10 (90%) charts reviewed revealed the assessment reflect the hospital findings and concurrence or deviation from the hospital recommendations.
Detainee released from the hospital with recommendations for a neurology follow-up in 3-4 weeks. Recommendations were not addressed timely.

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. Documents were not scanned into the appropriate section of the medical record consistently. For example consult notes were scanned into the consent section.

One chart had medications listed on the MAR but unable to find orders for medications.

Lab was ordered to be drawn on 8/24/16 and were not drawn. A refusal was obtained and placed in the chart on 8/30/16

5 of 6 (83%) charts reviewed revealed the detainee was re-assessed by the provider at least every 30 days until the off-site service was completed.

6 of 7 (85%) charts reviewed the clinician acknowledged the specialist's report within seven days after the service was performed.

6 of 7 (86%) of charts reviewed revealed treatment plans were updated every 90 days. Although each detainee chart reviewed did have complete assessment, treatment plan and follow-up plan documented, the formal mental health treatment plan was not completed on each detainee. The formal mental health treatment plan is one which includes identification of strengths, weakness, treatment goals and interventions.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

10 of 10 (100%) of detainees had an indication for a mental health referral were referred appropriately and evaluated timely. They were evaluated by a qualified mental health provider daily while on suicide watch with appropriate monitoring and consistent documentation. No issues were identified.

Health Assessment

Previous finding from FMC site visit on May 10, 2016
51 of 52 (98%) charts reviewed had a complete evaluation within 14 days of booking to include vital signs, adequate medical and mental health history.

Twenty charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area. Initial screenings were completed within 12 hours of booking; TB screening completed within 48-72 hours; detainees who screened positive for mental illness or suicide risk were referred appropriately; there was timely follow up for significant findings of acute or chronic conditions; and a complete health evaluation was done within 14 days.
No issues were identified.

Urgent Care (Sick Call)

Previous finding from May 10, 2016 site visit
18 of 19 (95%) charts reviewed were not seen by a provider timely. No issued noted during this site visit.

10 charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.
9 of 10 (90%) reviewed revealed a nursing referral was submitted within 24 hours where appropriate. Detainee was assessed during sick call and found to have a fever (100.4) and heart rate of 107. The nurse treated the detainee using nursing protocols.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Previous finding from May 10, 2016 site visit
14 of 15 (93%) of charts reviewed had an inbound assessment. No issues noted during current site visit.

10 charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

9 of 10 (90%) charts reviewed revealed the assessment reflect the hospital findings and concurrence or deviation from the hospital recommendations.
Detainee released from the hospital with recommendations for a neurology follow-up in 3-4 weeks. Recommendations were not addressed timely.

Medication Administration Practices

Previous finding from May 10, 2016
One MAR had one blank.

10 charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area. No issues were identified.

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Continuity of Medication

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. No issues were identified.

Mental Health Screen

Previous deficiency from May 10, 2016 site visit:
19 of 20 (95%)charts reviewed with a positive mental health screen and referred to see a qualified mental health was seen in a timely manner: emergent are seen immediately, urgent are seen within 24 hours and routine are seen within seven days. No issues were identified during current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. No issues were identified.

Medical Recordkeeping Practices

Previous finding from May 10, 2016
Telephone orders were not consistently cosigned by the provider.
The problem list page was not consistently completed on all detainees in particular detainees with mental illness, asthma and seizure disorders. No issues were identified during current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. Documents were not scanned into the appropriate section of the medical record consistently. For example consult notes were scanned into the consent section.

One chart had medications listed on the MAR but unable to find orders for medications.

Pregnant Women

10 charts were reviewed using the IHSC Quality of Care Audit Tool.

10 of 10 (100%) of charts reviewed of pregnant females found they had lower bunk orders, prenatal vitals, and order for restricting the use of restraints. An obstetric consult was ordered within seven days of identification of the pregnant detainees and an appointment was scheduled within 30 days.

In addition to the standards set forth by PBNDS (2011), all were screened for the Zika virus and given long sleeved shirts and mosquito repellent. They were also all screened by a qualified mental health provider upon identification of pregnancy status.

Dental Care

Ten charts were reviewed using the IHSC Quality of Care audit tools

10 of 10 (100%) of charts reviewed found all were screened for symptoms during the intake process and two were referred to the dental provider and evaluated within 48 hours. The dental clinical notes described findings, diagnosis and treatment plans.

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Acute Laboratory Testing

Eight charts reviewed with lab orders using the IHSC Quality of Care Audit Tool

7 of 8 (88%) lab orders reviewed were found to have been drawn within 1 business day of the order or within the time frame ordered. The results were back within 24 hours. The lab results were clinically acknowledged with the appropriate response. The results were discussed with the detainee at a follow-up appointment.

Lab was ordered to be drawn on 8/24/16 but was not drawn. A refusal was obtained and placed in the chart on 8/30/16.

Diagnostic Services and Specialty Care Access

Previous finding from May 10, 2016
12 of 13 (93%) of charts reviewed, which had an appointment scheduled and completed, did not have the facility clinician acknowledging the specialist's report in the medical record within seven days of the date the service was performed. This remains an issue during current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit Tool
5 of 6 (83%) charts reviewed revealed the detainee was re-assessed by the provider at least every 30 days until the off-site service was completed.
6 of 7 (85%) charts reviewed showed the clinician acknowledged the specialist's report within seven days after the service was performed.

Mental Health Treatment Planning

Previous finding from May 10, 2016
19 of 20 (95%)of charts reviewed from the mental health caseload had a mental health clinical assessment, treatment, and follow-up plan documented. This remains an issue during current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
6 of 7 (86%) of charts reviewed revealed treatment plans were updated every 90 days. Although each detainee chart reviewed did have complete assessment, treatment plan and follow-up plan documented, the formal mental health treatment plan was not completed on each detainee. The formal mental health treatment plan is one which includes identification of strengths, weakness, treatment goals and interventions.

Treatment of Disability

10 charts were reviewed using the IHSC Quality of Care Audit Tool. No issues were identified

Complaints and Grievances

Grievance logs were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
41 grievances were submitted over the past three months. All were appropriately addressed within five working days. No issues or trends were identified during current site visit.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Previous finding from May 10, 2016
18/19 (95%) of charts reviewed has a blood sugar measured and recorded on intake. No issues were identified during current site visit.

10 charts were reviewed using the IHSC Quality of Care Audit Tool. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage diabetic detainees.

Human Immunodeficiency Virus (HIV)

Nine charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
8 of 9 (89%) charts reviewed revealed a chest x-ray was completed within 72 hours of problem identification.

One detainee did not reveal his HIV status upon intake or physical assessment. Once identified, labs were ordered and appropriate follow-up however; a chest x-ray was not ordered.
Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage HIV detainees.

Hypertension

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with hypertension.

Asthma

Previous finding from May 10, 2016 site visit
14 of 16 (88%) of charts reviewed had a peak flow at the initial physical exam. No issues noted during current site visit

10 charts were reviewed using the IHSC Quality of Care Audit tool. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with asthma.

Seizure Disorder

Previous finding from May 10, 2016
11 of 12 (92%) of charts reviewed have orders for lower bunk. No issues were identified during current site visit

Seven charts were reviewed using the IHSC Quality of Care Audit tool. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with seizure disorders.

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Recommendations

(b)(5)

Facility Actions

Adelanto has updated audit tools to include mental health treatment plans are in place.
Adelanto has updated audit tools to include reviewing records of detainees returning from outside hospital visits and outside consultants.
The medical director is reviewing weekly documents requiring co-signature by a provider to ensure education and completion of signatures.

Additional Comments

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End of Report

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Phone Number: +1 (612) 843-(b)(6); (b)(7)(C)	Date Reviewed: 06/04/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Field Medical Coordinator (A)
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (612) 843-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 06/06/2017

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
03/06/2018	08/29/2017	Adelanto ICE Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C) IHSC HQ	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,534	1,320	214	0	1

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
38	32	6	2	0	25

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561- (b)(6); (b)(7)(C)	Phone Number: +1 (760) 561- (b)(6); (b)(7)(C)
Address: 10400 Rancho Road Adelanto, CA 82301	Address: 10400 Rancho Road Adelanto, CA 82301

Medical Care

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☒ >3 Standards

Description of deficiencies:

PBNDS 4.3: V.C.2
Tuberculosis Screening Management- Screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.
All new arrivals shall receive TB screening within 12 hours of intake and in accordance with CDC guidelines (www.cdc.gov/tb).

FINDINGS: One out of nineteen (5%) did not have tuberculosis screening completed as per CDC guidelines. One of the detainee's chest x-ray was not read within 72 hours due to "housing issues." The chest x-ray was ordered five days after arrival. The chest x-ray was completed nine days after arrival.

PBNDS 4.3: V.S.4
Sick Call- Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

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FINDINGS: Two of three (67%) of the charts reviewed for urgent care (sick call) did not have a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate.

PBNDS 4.3: V.U.5
Medical Care- Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.

FINDINGS: Two of ten (20%) of the charts reviewed indicated that the detainees did not receive their medication within 24-72 hours. One detainee's medication was not ordered at intake because the personal supplies were in Russian, and the nurse could not read them. The detainee went without several cardiac medications for 2-3 days until seen by a provider. In a second detainee, the transfer summary noted a history of asthma, but no medical conditions or medications were documented on the intake screening, and no medications were ordered until the exam 5 days later.

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Ten detainees were assessed for assistance with activities of daily living (ADL), and appropriate accommodations ordered. Three out of ten (30%) were missing appropriate accommodation orders (Special needs). The facility does not clearly determine in the progress notes if the provider has assessed the detainees for assistance with activities of daily living.

PBNDS 6.2: V.C.4
Medical Grievances- Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale. This record shall be maintained per the following section "D. Record-Keeping and File Maintenance."

FINDINGS: Four out of thirty-six (11%) of the grievances were not addressed within 5 working days of receipt.

Previous Site Visit 08/29/2017
Sick Call
FINDINGS: Two of ten (20%) of the charts reviewed for urgent care (sick call) did not have timely and appropriate nursing evaluations for the different acute conditions. One detainee was rescheduled for nursing sick call 3 times and another 5 times.

One of ten (10%) detainees seen on nursing sick call did not have vital signs documented with the nursing assessment.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
547	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
PBNDS 4.3: V.C.4.c - Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

FINDINGS: Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of

AMERICAN OVERSIGHT

problem identification, if not already done. In one instance, the detainee was identified on July 20, 2017; however, the chest x-ray was not completed until July 28, 2017. The other detainee was identified as being HIV positive on January 31, 2017. The chest x-ray was completed on May 26, 2017.(REPEAT FINDING)

Previous findings from 08/29/2017 FMC Site Visit
PBNDS 4.3: V.C.4.c
Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

NCCHC J-G-01 Chronic Disease Services

Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
One of six (16%) detainees was not seen by an HIV or ID specialist within 30 days of HIV identification. The detainee was identified as being diagnosed with HIV on September 3, 2016; however, the detainee was not scheduled for ID visit until December 16, 2016.

Two of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification. For one detainee, the diagnosis was identified on July 29, 2017; however, the chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive HIV on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

A review of the facility's chronic care detainees with asthma, hypertension, diabetes and seizure disorder were noted to follow NCCHC and PBNDS standards.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	7

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were a total of 7 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

Previous findings from 08/29/2017 FMC Site Visit
There were 10 hunger strikes in the last 12 months. One detainee went on hunger strike 6 times, and the other 4 were different detainees. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
1	250

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no deficiencies noted regarding this section of the standard. The facility continues to have 2 cells available for suicide watch. Detainees who are determined to be suicidal are evaluated by a mental health provider and are either placed on a constant or staggered (15 minute checks) suicide watch at the facility. If the cells are occupied or if it a serious suicide attempt, the detainee is sent out to the local hospital for further evaluation and treatment.

The facility continues to utilize the Alvarado Parkway Institute (API) located in San Diego, CA as the preferred inpatient mental health facility.

On February 15, 2018, CCS and the FMC had an on-site meeting with the administration and psychiatrist at API. Treatment planning was discussed with the psychiatrist to include starting detainees on long-acting antipsychotic medications when appropriate. The psychiatrist at API reassured CCS that they will work together to manage the mental health care of detainees who are admitted to API.

Previous findings from 08/29/2017 FMC Site Visit
No deficiencies were noted regarding this section of the standard.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	3

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit on 08/29/2017.

Previous findings from 08/29/2017 FMC Site Visit
There were 3 reported deaths in the last 12 months. As of March 23, 2018, the mortality reports are still pending.
1. A 32 year old male died March 28, 2017 at the Victor Valley Hospital. He was found hanging in a restrictive housing unit cell on March 22, 2017. He was admitted to the hospital with the following diagnoses: coma, sever hypoxic encephalopathy, status post full cardiopulmonary arrest, respiratory failure and attempted suicide by self-hanging. Detainee had a history of mental health problems and had recently been hospitalized for his mental health disorder. Final mortality reports are still pending.
2. A 55 year old male died April 14, 2017 at Victor Valley Hospital after being admitted on April 1, 2017 for hemoptysis. He was admitted for work up and treatment for GI bleed, anasarca, sepsis, and leukocytosis. Further workup revealed anemia and cirrhosis of the liver. Esophageal banding was performed on April 4, 2017 and the bleeding stopped. On April 13, 2017, he was being prepared for discharge when he felt dizzy and collapsed in bed. A code blue was called. However, he did not recover from this episode, and he was pronounced dead on April 14, 2017. Final mortality reports are pending.
3. A 46 year old male died May 31, 2017 after collapsing while playing soccer. He was transported to the emergency department where he was pronounced dead. Final mortality reports are pending. The detainee arrived to Adelanto on May 22, 2017 with a significantly high blood pressure and was placed in the infirmary and received a dose of clonidine and was prescribed other blood pressure medications. He was discharged from the infirmary the following day with an order for blood pressure checks, routine labs and an EKG with a follow-up in three to four weeks. Final mortality reports are pending.
The FMCs will address any negative findings from the mortality reports once received.

There are no detainees with terminal illness or detainees with advance directives within the

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last 12 months. The facility's policy was reviewed, and there were no areas of concern related to the policies.

Other Observations

The Adelanto ICE Processing Center (APC) IHSC Site visit was conducted March 6, 2018 through March 8, 2018. The site visit was completed by (b)(6); (b)(7)(C) IHSC Health Care Compliance Unit Deputy Assistant Director; (b)(6); (b)(7)(C) IHSC Medical Case Management Unit Chief; (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) IHSC Health System Support Deputy Assistant Director; (b)(6); (b)(7)(C) IHSC Los Angeles Field Medical Coordinator; (b)(6); (b)(7)(C) Western Regional Pharmacy Consultant; (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) IHSC Field Medical Coordinator; (b)(6); (b)(7)(C) Risk Manager; and (b)(6); (b)(7)(C) Psychiatrist. The IHSC team piloted the new Quality of Medical Care (QMC) audit tools during the review.

APC is an ICE dedicated IGSA with only detainees. APC operates under The Geo Group Inc. which contracts with Correct Care Solutions (CCS) to provide on-site medical care. CCS has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 (Revised 2016) Performance Based National Detention Standards (PBNDS). APC received their National Commission on Correctional Health Care (NCCHC) accreditation on April 10, 2016; American Correctional Association (ACA) Accreditation January 23, 2017; Nakamoto Annual Audit October 3-5, 2017; and a Disability Rights California (DRC) visit February 1, 2018. The facility currently houses approximately 214 female and 1320 male detainees.

APC currently utilizes both paper and electronic medical records. APC began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Documentation prior to August 30, 2016 remains on paper and documentation following August 30, 2016 is electronic. Medication administration, consents, intake screenings, and refusals are paper records and scanned into the electronic record.

CURRENT STAFFING:

(b)(7)(E)

Deficiencies for Areas Evaluated

PBNDS 4.3: V.C.2
Tuberculosis Screening Management- Screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.
All new arrivals shall receive TB screening within 12 hours of intake and in accordance with CDC guidelines (www.cdc.gov/tb).

One out of nineteen (5%) did not have tuberculosis screening completed as per CDC guidelines. One of the detainee's chest x-ray was not read within 72 hours due to "housing issues." The chest x-ray was ordered five days after arrival. The chest x-ray was completed nine days after arrival.

PBNDS 4.3: V.S.4
Sick Call

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Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

FINDINGS: Two of three (67%) of the charts reviewed for urgent care (sick call) did not have a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate.

PBNDS 4.3: V.U.5
Medical Care- Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.

FINDINGS: Two of ten (20%) of the charts reviewed indicated that the detainees did not receive their medication within 24-72 hours.

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Seven out of ten (70%) were assessed for assistance with activities of daily living (ADL), and appropriate accommodations were ordered. Three were missing appropriate accommodation orders (Special needs). The facility does not clearly determine in the progress notes if the provider assessed the detainees for assistance with activities of daily living.

PBNDS 6.2.4
Medical Grievances- Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale. This record shall be maintained per the following section "D. Record-Keeping and File Maintenance."

FINDINGS: Four out of thirty-six (11%) of the grievances were not addressed within 5 working days of receipt.

PBNDS 4.3: V.C.4.
Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

FINDINGS:
Two out of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainee was identified on July 20, 2017; however, the chest x-ray was not completed until July 28, 2017. The other detainee was identified as being HIV positive on January 31, 2017. The chest x-ray was completed on May 26, 2017.(REPEAT FINDING)

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Quality of Care Issues Identified:

Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care
Two out of nine (22%) of detainees did not have an inbound progress note and an inbound assessment on return from the hospital.

Medication Administration Records
One out of two (50%) did not have an appropriate response by the provider for refusal of medications.

Medical Record Keeping
Two out of ten (20%) charts reviewed were not in compliance with Progress notes. Two of the charts reviewed, the notes were incomplete and not in a SOAP format.

Two of ten (20%) charts reviewed were not in compliance with updating the problem list.

Laboratory Testing
Four out of ten (40%) did not have laboratory testing done within one business day of the ordered date or by the due date. There were marked delays, one to two weeks from date desired, in lab drawing of routine labs due to the list being full.

One out of ten (10%) patients did not have clinical acknowledgment of laboratory tests.

Nine out of ten (90%) patients were not advised of laboratory results. There was a trend in lack of documentation of teaching on lab results.

Diabetes
One out of nine (11%) of detainees did not have a blood sugar measured and recorded on intake.

One of ten (10%) of detainees with diabetes did not have a baseline HgbA1c performed within 30 days of intake or within the past 3 months.

One of ten (10%) of detainees with diabetes was not followed at least every 90 days with appropriate vital signs.

One out of five (20%) of detainees did not have aspirin prescribed, as clinically indicated. A 47 year old female detainee with hypertension, and diabetes, was not prescribed aspirin.

One of ten (10%) of detainees did not have the degree of control (goal HgbA1C <8) documented. His HgbA1C was 8.5. In addition, one detainee showed at least five instances of low blood sugar ranging from 37 mg/dL - 52 mg/dl, symptomatic with no change in his diabetes medications, also demonstrating lack of control in management of diabetes.

Hypertension
One of ten (10%) did not have a documented blood pressure reading at intake. The history and physical was completed 2 days after intake and a normal blood pressure reading was recorded.

Asthma
Two out of ten (20%) did not have a peak flow completed at the initial physical exam. One detainee had an initial exam performed on February 7, 2018, and the peak flow was performed on February 22, 2018. One detainee had an initial exam performed on March 6, 2017, and the peak flow was performed on March 29, 2017. This is a repeat finding.

Seizure
Two out of six (33%) detainees did not have appropriate neurological history completed at the initial physical examination. Two detainees did not receive a thorough neurological history at the initial exam.

Five out of six (83%) detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification. One detainee was seen in CCC by mid-level at five weeks post

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illness identification.

Previous findings from 08/29/2017 FMC Site Visit
The following PBNDS 2011 deficiencies were noted:

PBNDS 4.3: V.S.4
Sick Call

Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

FINDINGS: Two of ten (20%) of the charts reviewed for urgent care (sick call) did not have timely and appropriate nursing evaluations for the different acute conditions. One detainee was rescheduled for nursing sick call 3 times and another 5 times, which resulted in delay of evaluation and care for 2 weeks for detainees complaining of eye and back pain.

One of ten (10%) detainees seen on nursing sick call did not have vital signs documented with the nursing assessment.

PPBNDS 4.3: V.C.4.c
Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

NCCHC J-G-01 Chronic Disease Services

Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
Two of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification. For one detainee, the diagnosis was identified on July 29, 2017, however chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

Quality of care issues:
Urgent Care (Sick Call):
Eight of ten (80%) of the charts reviewed for urgent care (sick call) had timely and appropriate nursing evaluations for the different acute conditions. The detainee with the complaints of back pain was rescheduled five times before being evaluated. The detainee with the complaints of the eye pain was rescheduled three times before being evaluated. The detainee with the back pain was rescheduled on March 14, March 15, March 16, March 17, March 18 and was eventually evaluated on April 4 during chronic care for the complaint. The detainee with the eye pain was rescheduled on April 16, April 27 and April 28 and was eventually evaluated on April 30. There is no documentation in the medical records regarding why the detainees were rescheduled. According to the HSA, the reschedules could have been due

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to a variety of factors including provider schedules, medical emergencies, lack of custody to transport the detainee to the clinic, etc. Effective June 2017, the HSA is monitoring the scheduled sick call on a daily basis to review the number scheduled, seen, refused, canceled or rescheduled and the type of complaint for those that were rescheduled if applicable.

Nine of ten (90%) had vital signs documented with the nursing assessment. No vital signs were taken for a detainee complaining of eye pain.

Evaluation of Care Prior to Emergency Department:

One of ten (10%) charts revealed that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.

In one case, there was a delay in obtaining a laboratory test. The test was ordered on March 18, 2017 however, it was not obtained until April 3, 2017.

Diagnostic Services and Specialty Care Access:

Nine of ten (90%) of the specialty charts reviewed had time urgency documented on the order for specialty care, the appointment was accomplished within the ordered time frame, and the provider acknowledged the specialist's report within 7 days from the performed date of service.

One of the detainees was referred to the ENT on December 29, 2016; the MedPAR was submitted to IHSC on February 21, 2017. There is no documentation in the medical record regarding why there was a delay in submitting the MedPAR. The appointment was completed on March 6, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the ENT appointment. The detainee was released from detention on March 28, 2017.

Three out of four (75%) were evaluated at least every 30 days until the consult was completed. One of the detainees was referred to the OB/GYN on February 13, 2017, and the appointment was on March 7, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the GYN appointment.

Diabetes:
Five of six (90%) of detainees had aspirin prescribed, as clinically indicated. In one instance aspirin was not prescribed as indicated for a 55 year old detainee with hyperlipidemia, hypertension, and positive family history.

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Suicide Screening

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

There were a total of 43 patients placed on suicide watch in the last three months. The facility uses an acceptable suicide risk management screening instrument including at minimum, asking for a history of suicide attempts and for current suicidal ideation. All screeners and all staff in direct contact with detainees are trained to assess suicide risk. Logs were provided by the facility.

Ten out of ten (100%) of detainees had checks documented consistently.

Ten out of ten (100%) detainees were evaluated by a qualified mental health professional within 24 hours of identification.

Nine out of nine (100%) of detainees were evaluated by a qualified mental health professional daily while on suicide watch.

Ten out of ten (100%) of detainees showed no evidence that earlier intervention might have prevented deterioration to the point of need for suicide watch.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of detainees had an indication for a mental health referral were referred appropriately and evaluated timely. They were evaluated by a qualified mental health provider daily while on suicide watch with appropriate monitoring and consistent documentation. No issues were identified.

Health Assessment

20 charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

20 out of 20 (100%) of charts reviewed had an initial screen completed within 12 hours of booking.

18 out of 19 (95%) had tuberculosis screening completed as per CDC guidelines. One of the detainee's chest x-ray was not read within 72 hours due to "housing issues." The chest x-ray was ordered five days after arrival. The chest x-ray was completed nine days after arrival.

Ten out of ten (100%) of detainees who screened positive for mental health or suicide risk were referred for an evaluation.

Twenty out of twenty (100%) of those identified with an acute or chronic condition during intake screening had timely follow-up for their significant findings and a complete health evaluation within 14 days of intake.

Previous findings from 08/29/2017 FMC Site Visit
Twenty charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

20 of 20 (100%) of charts reviewed had an initial screen completed within 12 hours of booking.

18 of 18 (100%) had tuberculosis screening completed as per CDC guidelines. Two of the detainees had a chest x-ray completed at the transferring facility.

11 of 11 (100%) of detainees who screened positive for mental health or suicide risk were referred for an evaluation. The other 9 detainees did not have a positive mental health screen.

20 of 20 (100%) of those identified with an acute or chronic condition during intake screening had timely follow-up for their significant findings and a complete health evaluation within 14 days of intake.

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Urgent Care (Sick Call)

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of the charts reviewed for urgent care (sick call) had timely and appropriate nursing evaluations depending on the nature of the complaint.

Ten of ten (100%) of care was delivered within the scope of the nurse's license.

Ten of ten (100%) had vital signs documented with the nursing assessment.

One of three (33%) had a nursing referral to a nurse practitioner submitted within 24 hours.

One of one (100%) detainee who was referred to a provider had an assessment and treatment plan documented by the nurse practitioner.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Eight of ten (80%) of the charts reviewed for urgent care (sick call) had timely and appropriate nursing evaluations for the different acute conditions. The detainee with the complaints of back pain was rescheduled five times before being evaluated. The detainee with the complaints of the eye pain was rescheduled three times before being evaluated. The detainee with the back pain was rescheduled on March 14, March 15, March 16, March 17, March 18 and was eventually evaluated on April 4 during chronic care for the complaint. The detainee with the eye pain was rescheduled on April 16, April 27 and April 28 and was eventually evaluated on April 30. There is no documentation in the medical records regarding why the detainees were rescheduled. According to the HSA, the reschedules could have been due to a variety of factors including provider schedules, medical emergencies, lack of custody to transport the detainee to the clinic, etc. Effective June 2017, the HSA is monitoring the scheduled sick call on a daily basis to review the number scheduled, seen, refused, canceled or rescheduled and the type of complaint for those that were rescheduled if applicable.

Ten of ten (100%) of care was delivered within the scope of the nurse's license.

Nine of ten (90%) had vital signs documented with the nursing assessment. No vital signs were taken for a detainee complaining of eye pain.

Six of six (100%) had a nursing referral to a nurse practitioner submitted within 24 hours.

Six of six (100%) of the detainees who were referred to a provider had an assessment and treatment plan documented by the nurse practitioner.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees had an outbound progress note.

Ten out of ten (100%) charts revealed no evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.

Ten out of ten (100%) of detainees had discharge documentation from the hospital or emergency department (ED) in the chart.

Seven out of nine (78%) of detainees had an inbound progress note and an inbound assessment. Two detainees had no inbound assessment on return from the hospital.

Eight out of eight (100%) of detainees had an assessment that reflected hospital findings and concurrence or reason for deviation from the hospital recommendations.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

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Ten out of ten (100%) of detainees had an outbound progress note and an inbound assessment, as well as an assessment that reflected hospital findings and concurrence or reason for deviation from the hospital recommendations. Detainees were also found to have discharge documentation from the hospital or emergency department (ED) in the chart.

Nine out of ten (90%) charts revealed no evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.

In one case, there was a delay in obtaining initial routine blood work after history and physical which included a complete metabolic panel. Test was ordered on March 18, 2017 and was not collected until April 3, 2017. Detainee was sent to the emergency room for hyperglycemia on April 5, 2017.

Medication Administration Practices

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Two out of two (100%) had documentation in the medical record that the prescribing provider was notified of consecutive refusals.

One out of two (50%) had an appropriate clinician response.

In one case, a provider acknowledged in an encounter that the nursing staff had informed the provider that a patient was refusing morning insulin, but continued the patient's sliding scale insulin order as twice daily. The printed MAR from CorrectRx for March shows the provider's order for twice daily insulin, but the nursing staff hand-wrote the order on a separate MAR as every evening. There were no signed refusal forms in the patient's chart for insulin in 2018. The nine other charts reviewed yielded a total of 14 refusals or no-shows on MARs, of which 2 lacked a signed refusal form. All of these charts showed an appropriate clinician response to consecutive refusals.

The facility has a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up.

Approximately 30% of MARs reviewed had either blanks, consecutive refusals, or no shows.

All previous month MARs were filed in the detainee medical records.

Over the counter (OTC) medications are provided by medical and the commissary.
Previous findings from 08/29/2017 FMC Site Visit
Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Two of two (100%) of detainees had documentation in the medical record that the prescribing physician was notified of consecutive refusals. No issues were identified.

Two out of two (100%) detainees had an appropriate response from the clinician (i.e., was the patient was interviewed or the prescription was changed or discontinued. No issues were identified.

The facility has a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up.

Approximately 3% of MARs reviewed had either blanks, consecutive refusals, or no shows.

All previous month MARs were filed in the detainee medical records.

Approximately 70% of patients are on self-administered medications.

Over the counter (OTC) medications are provided by medical and the commissary.

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Continuity of Medication

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Eight of ten (80%) of the charts reviewed indicated that detainees are consistently receiving their medication within 24-72 hours. Immediately following the detainee's intake encounter, the nurse sends an electronic notification to the provider to order the patients' chronic medications, and the medication is generally received within one business day. One detainee's medication was not ordered at intake because the personal supplies were in Russian, and the nurse could not read them. The detainee went without several cardiac medications for 2-3 days until seen by a provider. In a second detainee, the transfer summary noted a history of asthma, but no medical conditions or medications were documented on the intake screening, and no medications were ordered until the exam 5 days later.

Ten of ten (100%) of the charts reviewed indicated that detainees are receiving the first dose of their medication less than 24 hours from when it was ordered.

Previous findings from 08/29/2017 FMC Site Visit
10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of detainees had medications ordered less than 24 hours from completion of intake screening, and received their first dose in less than 24 hours from the order. No issues were identified.

Mental Health Screen

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a positive screen for mental illness or suicide risk and were referred for evaluation by a mental health provider in a timely manner.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a positive screen for mental illness or suicide risk and were referred for evaluation by a mental health provider in a timely manner.

Medical Recordkeeping Practices

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Eight of ten (80%) charts reviewed were in compliance with updating the problem list. Seven of ten (70%) charts reviewed were in compliance with the receiving screen and health assessment forms. Three of the charts reviewed, the health assessments were not found in the record. East side dental provided an the encounter note that stated dental assessment was completed, but no scanned document of the assessment. The West side clearly does this accordingly, but the East side is not standardized in this procedure.

Eight out of ten (80%) charts reviewed were in compliance with Progress notes. Two of the charts reviewed, the notes were incomplete and not in a SOAP format.

The remaining medical record-keeping practices were in compliance or not applicable.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. APC utilizes both paper and electronic medical records. They began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Medication administration, consents, refusals, and some intake screenings are documented on paper records and then scanned into the electronic record.

Ten of ten (100%) revealed that the medical record-keeping practices are in compliance or non-applicable.

Pregnant Women

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Two charts were reviewed using the IHSC Quality of Care Audit Tool as there were only two pregnant detainees within the last 6 months at the facility.

APC performs pregnancy tests on all females prior to x-ray or initiation of medications.

Two of two (100%) had an OB/GYN consult ordered within 7 days of pregnancy confirmation and were seen within 30 days.

Two of two (100%) were screened for HIV, STI, and viral hepatitis and prescribed prenatal vitamins. No issues were identified.

Previous findings from 08/29/2017 FMC Site Visit
Two charts were reviewed using the IHSC Quality of Care Audit Tool as there were only two pregnant detainees within the last 6 months at the facility.

APC performs pregnancy tests on all females aged 10-54 during intake screening, prior to x-ray or initiation of medications.

Two of two (100%) had an OB/GYN consult ordered within 7 days of pregnancy confirmation and were seen within 30 days.

Two of two (100%) were screened for HIV, STI, and viral hepatitis and prescribed prenatal vitamins.

Dental Care

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of charts reviewed found all were screened for symptoms during the intake process.

Ten of ten (100%) of those who requested dental services, were referred to the dental provider and evaluated within 48 hours. The dental clinical notes described findings, diagnosis and treatment plans.

Five out of five (100%) were scheduled and seen for a follow-up appointment as recommended. No issues were identified.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care audit tools to evaluate this area.

Ten of ten (100%) of charts reviewed found all were screened for symptoms during the intake process, and two were referred to the dental provider and evaluated within 48 hours. The dental clinical notes described findings, diagnosis and treatment plans. No issues were identified.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Six out of ten (60%) patients had laboratory testing done within one business day of the ordered date or by the due date. There were marked delays, one to two weeks from date desired, in lab drawing of routine labs due to the list being full.

Ten out of ten (100%) patients who had labs drawn, routine results were back within 7 days and acute results were back in 24 hours; the results were acknowledged by a clinician with an appropriate response.

Nine out of ten (90%)patients had clinical acknowledgment of laboratory tests.

Nine out of nine (100%) patients charts had an appropriate clinical response.

One out of ten (10%) patients were advised of laboratory results. There was a trend in lack of documentation of teaching on lab results.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
Ten of ten (100%) of the patients had laboratory testing done within one business day of the ordered date or by the due date.

Ten of ten (100%) of the patients who had labs drawn, routine results were back within 7 days and acute results were back in 24 hours; the results were acknowledged by a clinician with an appropriate response.

Diagnostic Services and Specialty Care Access

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) of the specialty charts reviewed had time urgency documented on the order for specialty care.

Seven of seven (100%) the appointment was accomplished within the ordered time frame. Three of the detainees were released or removed prior to the appointment dates.

Seven out of seven (100%) were re-evaluated after 30 days until their off-site consult was completed.

Eight out of eight (100%) the clinician acknowledged the specialist's report in the medical record within 7 days of the appointment.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Nine of ten (90%) of the specialty charts reviewed had time urgency documented on the order for specialty care and the appointment was accomplished within the ordered time frame.

Three out of four (75%) were evaluated at least every 30 days until the consult was completed.

One of the detainees was referred to the ENT on December 29, 2016; the MedPAR was submitted to IHSC on February 21, 2017. There was no documentation in the medical record regarding why there was a delay in submitting the MedPAR. The appointment was completed on March 6, 2017; however, the detainee was not re-evaluated every 30 days and there was no follow-up by the provider after the appointment. The consultation was normal and acknowledged by the provider, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the ENT appointment. The detainee was released from detention on March 28, 2017.

Nine of ten (90%) of the specialty charts reviewed revealed that the provider acknowledged

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the specialist's report within 7 days from the performed date of service.

One of the detainees was referred to the OB/GYN on February 13, 2017, and the appointment was on March 7, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the GYN appointment.

Mental Health Treatment Planning

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees had a clinical assessment, treatment, and follow-up plan documented. In addition, treatment plans were updated at a minimum of every 90 days.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees had a clinical assessment, treatment, and follow-up plan documented. No issues were identified.

Nine out of nine (100%) of detainees had treatment plans updated at a minimum of every 90 days. No issues were identified.

Treatment of Disability

Ten charts was reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) reviewed had the disability noted in the file.

Seven out of ten (70%) were assessed for assistance with activities of daily living (ADL), and appropriate accommodations were ordered. Three were missing appropriate accommodation orders (Special needs). The facility does not clearly determine in the progress notes if the provider assessed the detainees for assistance with activities of daily living. For example, wheel chair bound detainees.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts was reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) had the disability noted in the file, the detainees was assessed for assistance with activities of daily living (ADL), and appropriate accommodations were ordered. The detainees did not require assistance with ADL's.

The facility maintains a current list of detainee with disabilities.

Complaints and Grievances

There were a total of 36 grievances reviewed for December 2017, January 2018 and February 2018. 32 of the 36 (89%) grievances were found in compliance with PBNDS 2011 of appropriately being addressed within 5 working days of receipt.

The grievance trends identified - 80% were due to delay in care complaints, 10% attitude demeanor or conduct and 10% other.

Previous findings from 08/29/2017 FMC Site Visit
Grievance logs were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. 40 grievances were submitted over the past three months. All were appropriately addressed within five working days. No issues or trends were identified during the current site visit. There were a total of six grievances due to availability of care; twelve due to denial or refusal of specific request for care; nine due to delay of care; one due to competency/ professional skillset of medical staff; two due to attitude, demeanor or conduct or staff, and 10 due to various other issues such as requesting personal property, being exposed to quarantine by sharing the recreation yard, etc.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area. The facility uses the BOP Diabetes Clinical Practice Guidelines.

Eight out of nine (89%) of detainees had blood sugar measured and recorded on intake.

Ten out of ten (100%) of detainees were seen for chronic care within fourteen days of illness identification, and had lipids measured within one year. No issues were found.

Nine out of ten (90%) of detainees had a baseline HgbA1c performed within 30 days of intake or within the past 3 months.

Ten out of ten (100%) of detainees had lipids measured within one year.

Nine out of ten (90%) of detainees were followed at least every 90 days with appropriate vital signs.

Four out of five (80%) of detainees had aspirin prescribed, as clinically indicated.

Nine out of ten (90%) of detainees had the degree of control (goal HgbA1C <8) documented. No issues were identified.

Eight out of eight (100%) of detainees had a strategy to attain diabetes control documented if HgbA1C was above goal.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

The facility uses the BOP Diabetes Clinical Practice Guidelines.

Seven out of seven (100%) of detainees had blood sugar measured and recorded on intake. No issues were identified.

Ten out of ten (100%) of detainees were seen for chronic care within seven days of illness identification, had lipids measured within one year, and were followed at least every 90 days with appropriate vital signs. No issues were found.

Nine of nine (100%) of detainees had a baseline HgbA1c performed within 30 days of intake or within the past 3 months. No issues were found.

Five of six (90%) of detainees had aspirin prescribed, as clinically indicated.

In one instance aspirin was not prescribed as indicated for a 55 year old detainee with hyperlipidemia, hypertension, and positive family history.

Eight out of eight (100%) of detainees had the degree of control (goal HgbA1C <7) documented. No issues were identified.

Four of four (100%) of detainees had a strategy to attain diabetes control documented if HgbA1C was above goal. No issues were identified.

Human Immunodeficiency Virus (HIV)

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees were seen by an HIV or ID specialist within 30 days of HIV identification.

Nine out of nine (100%) of detainees had a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months.

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Ten out of ten (100%) of detainees had anti-retroviral treatment considered and documented. No issues were found.

Nine out of nine (100%) of detainees were seen by a mid-level provider or physician for chronic care at least every 90 days.

Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainee was identified on July 20, 2017; however, the chest x-ray was not completed until July 28, 2017. The other detainee was identified as being HIV positive on January 31, 2017. The chest x-ray was completed on May 26, 2017.(REPEAT FINDING)

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage HIV detainees.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Five out of six (83%) of detainees were seen by an HIV or ID specialist within 30 days of HIV identification. In one instance, the detainee was identified as being HIV positive on September 3, 2016 and was not scheduled for a chronic care clinic (CCC) ID visit until December 16, 2016.

Eight out of eight (100%) of detainees had a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months. No issues were found.

Nine out of nine (100%) of detainees had anti-retroviral treatment considered and documented. No issues were found.

Four out of four (100%) of detainees were seen by a mid-level provider or physician for chronic care at least every 90 days. No issues were found.

Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainees was identified on July 29, 2017; however, the chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage HIV detainees.

Hypertension

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Nine of ten (90%) had documented blood pressure reading at intake. One of the detainees did not have a blood pressure reading at intake. The history and physical was completed 2 days after intake and a normal blood pressure reading was recorded.

Ten of ten (100%) of detainees with hypertension and were seen by an MD/PA/NP within 14 days of illness identification or sooner.

Six of six (100%) were noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.

Ten of ten (100%) were followed using the facility's hypertension guideline that included baseline laboratory testing.

APC uses the Bureau Of Prisons clinical practice guidelines to manage detainees with hypertension.

Previous findings from 08/29/2017 FMC Site Visit

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

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Ten of ten (100%) had documented blood pressure reading at intake and were seen by an MD/PA/NP within 14 days of illness identification.

Five of five (100%) were noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.

Ten of ten (100%) were followed using the facility's local hypertension guideline that included baseline laboratory testing.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with hypertension.

Asthma

Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten out of ten (100%) of detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification.

Eight out of ten (80%) and had a peak flow completed at the initial physical exam. One detainee had an initial exam performed on February 7, 2018, and the peak flow was performed on February 22, 2018. One detainee had an initial exam performed on March 6, 2017, and the peak flow was performed on March 29, 2017. (REPEAT FINDING)

Eight out of eight (100%) of detainees had a peak flow completed at the CC visit or within the last 3 months. No issues were identified.

Ten out of ten (100%) of detainees had a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with asthma.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts were reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Nine out of nine (100%) of detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification and had a peak flow completed at the initial physical exam. No issues were identified.

Eight out of nine (89%) of detainees had a peak flow completed at the initial exam. One detainee did not report asthma on intake however the medical transfer summary received by Adelanto noted a history of chronic asthma, therefore a peak flow should have been performed.

Ten out of ten (100%) of detainees had a peak flow completed at the CCC visit or within the last 3 months. No issues were identified.

Ten out of ten (100%) of detainees had a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control. No issues were identified.

Adelanto uses the Bureau Of Prisons clinical practice guidelines to manage detainees with asthma.

Seizure Disorder

Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Four out of six (67%) detainees had appropriate neurological history completed at the initial physical examination. Two detainees did not receive a thorough neurological history at the initial exam.

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Five out of six (83%) detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification. One detainee was seen in CCC by mid-level at five weeks post illness identification.

Two out of two (100%) detainees had serum drug levels performed and acknowledged in the medical record every three months until stable, then every six months where indicated. No issues were identified.

Five out of five (100%) detainees had a treatment plan established.

Six out of six (100%) detainees had orders for a bottom bunk.

Adelanto reports using no clinical practice guideline for seizure disorder.

Previous findings from 08/29/2017 FMC Site Visit
Ten charts reviewed with the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) detainees had appropriate neurological history completed at the initial physical examination. No issues were identified.

Ten out of ten (100%) detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification. No issues were identified.

Six out of six (100%) detainees had serum drug levels performed and acknowledged in the medical record every three months until stable, then every six months where indicated. No issues were identified.

Eight out of eight (100%) detainees had a treatment plan established. No issues were identified.

Ten out of ten (100%) detainees had orders for a bottom bunk. No issues were identified.

Adelanto uses no clinical practice guidelines to manage detainees with seizure disorders.

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

The Quality Improvement Committee is conducting several studies related to medical complaints and CAPs to ensure compliance. The information is shared with the FMC quarterly.

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During the week of March 12, 2018, CCS evaluated eCW to determine how to improve efficiency. The Clinical Director created some templates for the providers to ensure continuity of care and proper documentation.

Effective June 2017, the Health Services Administrator began monitoring sick call daily to ensure detainees are seen as scheduled and not rescheduled.

Effective December 11, 2017, a clinical coordinator began to monitor and coordinate daily the appointments in the clinic. The providers no longer manage their individual schedules. The clinical coordinator provides the HSA daily updates regarding the appointments in the clinic. The data from the clinical appointments includes refusals and reschedules is given to the Quality Control team weekly for tracking and trending. The information is being used to identify areas of improvement and to determine the effectiveness of the new process.

Additional Comments

The review provided by the Western Regional Pharmacy Consultant revealed that the Adelanto facility prescribes a significantly higher volume of psychotropic medications when compared to IHSC facilities of similar volume and acuity (Eloy, Jena, Krome, San Diego, and Tacoma) for 2017. Adelanto's total psychotropic medication use comprised 29% of all prescriptions filled; the average for the IHSC facilities was 15% (SD=3%). Adelanto patients received a total of 3,034 prescriptions for antipsychotic medications in 2017, compared to an average of 917 (SD=140) prescriptions for the same time period at the IHSC facilities. Further, the antipsychotics most frequently selected (quetiapine, olanzapine, and chlorpromazine) are generally considered to be the most sedating of all antipsychotics, and these medications comprised 65% of the antipsychotics prescribed at Adelanto, compared to an average of 27% (SD=11.7%) at IHSC facilities. Adelanto used nearly 8 times as much chlorpromazine as all 5 IHSC facilities combined. A highly skewed proportion of sedating antipsychotics may indicate that mental health staff are using antipsychotic medications as a form of chemical restraints instead of a therapeutic regimen. The facility also used tricyclic antidepressants much more frequently than most other IHSC facilities, 482 prescriptions vs an average of 160 (SD=147). This is concerning because tricyclics are one of the most toxic medications in a suicide attempt by overdose, and should be used with extreme caution in patients with a history of suicidal thoughts. One patient who was treated with a cocktail of quetiapine, divalproex, lithium, and haloperidol was charted on as being persistently asleep during attempted encounters; his antipsychotic medication continued to be increased due to suicidality, and an antidepressant was never prescribed.

A series of chart reviews revealed enormous discrepancies between patient MARs and the electronic health record. Adelanto medical providers are regularly failing to send medication discontinuation notices to CorrectRx, which has resulted in MARs that are more often incorrect than correct. As an example, one MAR contained 4 orders for quetiapine, 3 of which had been discontinued at least 2 months previously, and 3 orders for hydroxyzine, 2 of which had been discontinued the previous month. In another case, a patient requested to stop all psychotropic medications; the provider concurred in his review but left one of the patient's orders as active in the EHR. Adelanto also does not have any automated or electronic processes for documenting new medication orders on MARs; all new orders are handwritten by the nursing staff, increasing opportunities for transcription errors. The medication procurement and administration process is currently overseen by a LVN.

The following CAPs were updated during the site visit:

1. FMC Site Visit - February 2017 - Items still open. FMC will continue to monitor until twelve consecutive weeks of demonstrated compliance with signing off of telephone verbal orders.
2. Medical Complaint (b)(6); (b)(7)(C) - Items still open. After the site visit, the CAP was revised after CRCL reviewed the initial CAP responses and provided additional recommendations. Responses are pending.
3. (b)(6); (b)(7)(C) - Item remains open. Study to ensure detainees who return from consultation services or hospital discharges are evaluated upon return. If referred to provider, ensure that detainee is seen. FMC will continue to monitor.

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4. (b)(6); (b)(7)(C) - Item remains open. FMC will continue to monitor until 100% compliance for 12 consecutive weeks to ensure detainees are appropriately evaluated when referred to a provider.
5 (b)(6); (b)(7)(C) All items complete.
6. MQM Mortality Review - (b)(6); (b)(7)(C) Items still open. Fourteen day physical examinations not at 100% compliance for 12 consecutive weeks. FMC will continue to monitor.
7. Medical Complaint (b)(6); (b)(7)(C) - Item remains open. Study to observe timeliness of sick call response times and notification to patient of the management plan commenced February 1, 2018. Ongoing. FMC will continue to monitor until 12 consecutive weeks of compliance is achieved.

AMERICAN OVERSIGHT

End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809-(b)(6); (b)(7)(C)	Date Prepared: 03/23/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 03/26/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved: 04/09/2018
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Chief, Medical Case Management Unit
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 02/08/2019

Recommendations:

(b)(5)

AMERICAN OVERSIGHT

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
05/20/2019	09/24/2018	Adelanto ICE Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,810	1,556	254	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
50	34	16	24	4	36

Facility Administration

Health Services Administrator	Clinical Director
Name: Vacant	Name: (b)(6); (b)(7)(C)
Email:	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)
Address: 10400 Rancho road Adelanto, CA 82301	Address: 10400 Rancho road Adelanto, CA 82301

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 4.3.U.5
Delivery of Medication
Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications.

FINDINGS:
Two of ten (20%) of the charts reviewed indicated that patients did not receive their first dose of medication in less than 24 hours from arrival to the facility. Two received their first dose of medication in 48 hours.

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Ten detainees were assessed for assistance with activities of daily living (ADL), and appropriate accommodations ordered. The facility does not clearly determine in the progress notes if the provider has assessed the detainees for assistance with activities of daily living.

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Previous Site Visit 09/24/2018 FMC Site Visit
No deficiencies noted

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
255	0

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☒ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS 4.3.M
Comprehensive Health Assessment

Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition. Physical examinations shall be performed by a physician, physician assistant, nurse practitioner, RN (with documented training provided by a physician) or other health care practitioner as permitted by law.

FINDINGS:
Two out of ten (20%) detainees were not seen in Chronic Care Clinic by an advanced practice provider or physician within 14 days of asthma identification. One detainee was seen on the 15th day and another on the 22nd day.

PBNDS 4.3.C.4.
Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, the CDC and the Infectious Diseases Society of America.

NCCHC J-G-01 Chronic Disease Services

Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.

For patients enrolled in an HIV program, it is recommended that care be supervised by an HIV specialist who will initiate and change therapeutic regimens as medically indicated.

FINDINGS:
Two out of nine (22%) of detainees were not seen by an ID specialist within 30 days of HIV identification or arrival at the facility. One of the detainees arrived on March 8, 2019 and was scheduled to see ID. The ID's office rescheduled the appointment. The detainee was seen on May 24, 2019. One detainee arrived to the facility on September 28, 2018 and was seen by ID on December 5, 2018.

PBNDS 4.3.AA.7
Informed Consent and Involuntary Treatment
If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment.

FINDINGS:
Two out of eight (25%) detainees with a history of seizures did not have a serum drug level performed and acknowledged in the medical record every 3 months. Two of the detainees refused labs initially and the labs were rescheduled. One detainee arrived November 12, 2018; the lab was refused on March 7, 2019; lab reordered for June 12, 2019. Another detainee arrived October 31, 2019; refused labs May 14, 2019; labs reordered for June 11, 2019. There was no documentation that reasonable efforts were made to explain the necessity for the recommended labs.

Previous findings from 09/24/2018 FMC Site Visit

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No deficiencies noted

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were a total of 5 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

Previous findings from 09/24/2018 FMC Site Visit
There were a total of 3 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
1	271

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There was one suicide watch at the time of the site visit. No deficiencies were noted regarding this standard. Detainees who are determined to be suicidal are evaluated by a mental health provider and are either placed on a constant or staggered (15 minute checks) suicide watch at the facility. Detainees on suicide watch are evaluated by a mental health provider daily. The facility has 2 cells available for suicide watch. If the cells are occupied or if a serious suicide attempt is made, the detainee is sent out to the local hospital for further evaluation and treatment.

The facility continues to use Anaheim Global Medical Center (AGMC) as the primary mental health facility. If no beds are available then, Alvarado Parkway Institute (API) is utilized.

Previous findings from 09/24/2018 FMC Site Visit

There were no deficiencies noted regarding this section of the standard.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Previous findings from 09/24/2018 FMC Site Visit
There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Other Observations

The Adelanto ICE Processing Center (AIPC) IHSC Site visit was conducted May 20, 2019 through May 24, 2019. The site visit was completed by (b)(6); (b)(7)(C) the Los Angeles Field Medical Coordinators.

AIPC is a dedicated IGSA with only ICE detainees. The facility currently houses approximately 254 female detainees and 1556 male detainees. AIPC operates under The Geo Group Inc. which contracts with Wellpath, formally known as Correct Care Solutions (CCS) to provide on-site medical care. Wellpath has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 Performance Based National Detention Standards (PBNDS). AIPC has had several audits to include American Correctional Association (ACA) Accreditation January 23, 2017 (upcoming audit in October 2019); Nakamoto Annual Audit October 9-11, 2018; Disability Rights California (DRC) visit August 13-14, 2018; NCCHC February 11-13, 2019; and ODO inspection March 12-14, 2019.

AIPC utilizes both paper and electronic medical records. AIPC began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Documentation prior to August 30, 2016 remains on paper and is scanned into eCW. Consents and refusals are paper records and are scanned into the electronic record. Effective February 19, 2019, AIPC began utilizing an electronic medication administration record, sMARt.

(b)(7)(E)

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(b)(7)(E)

Deficiencies for Areas Evaluated

PBNDS 2011:

See Medical Care and Chronic Care Deficiencies above.

QUALITY OF CARE

Diabetes:
One of three (33%) of detainees did not have aspirin prescribed, as clinically indicated. In one instance aspirin was not prescribed for a 54 year old detainee with hypertension and elevated lipids.

Medical Recordkeeping Practices:
Two of ten (20%) charts did not have the problem list updated.

One out of three (33%) charts reviewed did not have the MAR in the record within 2 weeks of previous month.

Diagnostic Services and Specialty Care Access:
Two out of ten (20%) charts reviewed did not have the appointment accomplished within 45 days of the order or within the ordered time frame.

Two out of ten (20%) charts reviewed did not have clinician acknowledgment of the specialist's report in the medical record within 7 days of the date the service was performed.

Treatment of Disability:
Disability Accommodations Notification (DAN) Forms are not being scanned into the medical record.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QCM Tool

Health Assessment

See QCM Tool

Urgent Care (Sick Call)

See QCM Tool

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QCM Tool

Medication Administration Practices

See QCM Tool

AMERICAN OVERSIGHT

Continuity of Medication

See QCM Tool

Mental Health Screen

See QCM Tool

Medical Recordkeeping Practices

See QCM Tool

Pregnant Women

See QCM Tool

Dental Care

See QCM Tool

AMERICAN OVERSIGHT

Acute Laboratory Testing

See QCM Tool

Diagnostic Services and Specialty Care Access

See QCM Tool

Mental Health Treatment Planning

See QCM Tool

Treatment of Disability

See QCM Tool

Complaints and Grievances

See QCM Tool

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QCM Tool

Human Immunodeficiency Virus (HIV)

See QCM Tool

Hypertension

See QCM Tool

Asthma

See QCM Tool

Seizure Disorder

See QCM Tool

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

(b)(7)(E)

3) The facility implemented an eMAR system, sMARt in February 2019. The facility contacted their IT to determine how eCW and sMARt can communicate so that the MARs can be uploaded into eCW. The facility will continue to review sMARt for improvements.
4) The Medical Grievance Coordinator will begin ensuring that the Disability Accommodations Notification (DAN) Form is scanned into the detainee's medical record.

Additional Comments

The facility is scheduled for ACA audit in October 2019

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809-(b)(6); (b)(7)(C)	Date Prepared: 06/26/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 07/05/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/09/2019

Recommendations:

(b)(5)

AMERICAN OVERSIGHT

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Adelanto ICE Processing Cetner			
AOR:*	LOS			
Address:	10400 Rancho Rd			
City:	Adelanto		**County:**	San Bernardino
State:*	CA	**Zip:**	82301	
Inspection Information				
Start Date:*	9/24/2018			
End Date:*	10/1/2018			
Organization:*		IHSC		
# Detainees at Time of Visit:		1762		
Total Facility Population at Time of Visit:		1762		
Facility Capacity:				
Notes:	The Adelanto ICE Processing Center (AIPC) is an ICE dedicated IGSA with only detainees. AIPC operates under The Geo Group Inc. which contracts with Correct Care Solutions (CCS) to provide on-site medical care.			
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	2/19/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by: (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	10	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	100%	
DM	Diabetes	94%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	80%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	100%	
HTN	Hypertension	100%	
LT	Laboratory Testing	96%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	100%	
SS	Suicide Screening	75%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	92%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Lab Technician						
Assistant H.S.A.						
TOTAL						

AMERICAN OVERSIGHT

INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/24/2018			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		BOP Clinical Practice Guideline					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		10	10	9	10			
Total Met:		10	10	9	10			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	N/A - LOS	Yes			
3		Yes	Yes	Yes	Yes			
4		Yes	Yes	Yes	Yes			
5		Yes	Yes	Yes	Yes			
6		Yes	Yes	Yes	Yes			
7		Yes	Yes	Yes	Yes			
8		Yes	Yes	Yes	Yes			
9		Yes	Yes	Yes	Yes			
10		Yes	Yes	Yes	Yes			

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Type Text Here	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 9/25/2018

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP Clinical Practice Guidelines
Clinical (c)		
cDM-1	Was blood sugar measured and recorded on intake?	
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)	
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?	
cDM-4	Were lipids measured within one year?	
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?	
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.	
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?	
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?	

Total Applicable:		6	10	9	9	6	9	9	8
Total Met:		6	10	9	9	6	5	9	8
% Compliance:	94%	100%	100%	100%	100%	100%	56%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
3		N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	N/A - LOS	No	Yes	N/A - NLOS

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	N/A	Yes	Yes	Yes	Yes	No	Yes	Yes	
7		N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
9		N/A	Yes	Yes	Yes	Yes	No	Yes	Yes	
10		Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	No issues identifiied						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	9/27/2018			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP Clinical Practice Guidelines					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			10	10	10	7	10
Total Met:			10	10	10	7	10
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	Yes	Yes	Yes	Yes	
2		Patient Interview	Yes	Yes	Yes	Yes	Yes	
3		Patient Interview	Yes	Yes	Yes	Yes	Yes	
4		Patient Interview	Yes	Yes	Yes	Yes	Yes	
5		Recent Lab	Yes	Yes	Yes	N/A - LOS	Yes	
6		Patient Interview	Yes	Yes	Yes	Yes	Yes	
7		Patient Interview	Yes	Yes	Yes	N/A - LOS	Yes	
8		Patient Interview	Yes	Yes	Yes	Yes	Yes	
9		Patient Interview	Yes	Yes	Yes	Yes	Yes	
10		Patient Interview	Yes	Yes	Yes	N/A - LOS	Yes	

AMERICAN OVERSIGHT

HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/26/2018			
Facility (f)								
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y			
fHTN-1b:	If yes, what is the guideline?		BOP Clinical Practice Guideline					
Clinical (c)								
cHTN-1	Was a blood pressure reading noted at intake?							
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Total Applicable:		10	10	10	10			
Total Met:		10	10	10	10			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	8					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) - arrived 6/6/18 normal intake screening, transfer summary dated 6/4/18 indicated hx seizure no medication. H&P completed 6/23/18, history of seizure noted					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/24/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	N/A				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		7	8	3	8	8
Total Met:		7	8	3	8	8
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	N/A - LOS	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	N/A - NLOS	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	N/A - NLOS	Yes	Yes
7		N/A - NLOS	Yes	N/A - NLOS	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess timeliness of medication, as ordered.								
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).								
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.								
Guidelines:									
Remarks:	Type Text Here								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	9/24/2018					
Clinical (c)									
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?								
cCM-2	Period of time from order to first dose less than 24 hours?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	10/1/2018			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	8	10	5			
Total Met:		10	8	10	5			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	N/A - NLOS			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	N/A - NLOS			
8		Y	N/A - NLOS	Yes	N/A - NLOS			
9		Y	N/A - NLOS	Yes	N/A - NLOS			
10		Y	Yes	Yes	N/A - NLOS			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:	(b)(6); (b)(7)(C) refused offsite opthalmology appointment						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/26/2018		
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			10	8	5	8	
Total Met:			10	8	5	8	
% Compliance:	100%		100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1	(b)(6); (b)(7)(C)	Other	Yes	Yes	N/A - NLOS	Yes	
2		Other	Yes	Yes	N/A - NLOS	Yes	
3		Gastroenterology	Yes	Yes	Yes	Yes	
4		Other	Yes	Yes	Yes	Yes	
5		Opthalmology	Yes	N/A - LOS	N/A - LOS	N/A - LOS	
6		Opthalmology	Yes	Yes	N/A - NLOS	Yes	
7		Opthalmology	Yes	N/A - NLOS	N/A - NLOS	N/A - NLOS	
8		Other	Yes	Yes	Yes	Yes	
9		Other	Yes	Yes	Yes	Yes	
10		Other	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	The tool calculated cEED-2 as 0% however, the findings were 100% that an earlier intervention would not have prevented deterioration to the point of need for ED care.							
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	9/27/2018		
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	0	10	10	10	
% Compliance:	80%		100%	0%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Chest Pain	Yes	No	Yes	Yes	Yes	
2		Seizure	Yes	No	Yes	Yes	Yes	
3		Head laceration	Yes	No	Yes	Yes	Yes	
4		R/O DVT	Yes	No	Yes	Yes	Yes	
5		R/O Appendicitis	Yes	No	Yes	Yes	Yes	
6		R/O Detached Retina	Yes	No	Yes	Yes	Yes	
7		Post blunt head trauma	Yes	No	Yes	Yes	Yes	
8		Suicidal	Yes	No	Yes	Yes	Yes	
9		R/O Pancreatitis	Yes	No	Yes	Yes	Yes	
10		Retinal Detachment	Yes	No	Yes	Yes	Yes	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	(b)(6); (b)(7)(C) requesting for shoe support						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	10/1/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				Y		
fCG-2:	How many medical grievances were submitted over the past 3 months?			64			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			64			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	10	2	1	5	1	2	1
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	Select	Select	Select	Select	1
2		1	Select	Select	Select	Select	Select
3		Select	1	2	Select	Select	Select
4		1	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	1	Select
6		Select	Select	1	Select	Select	Select
7		Select	Select	1	Select	Select	Select
8		Select	Select	1	Select	Select	Select
9		Select	Select	Select	1	Select	Select
10		Select	Select	Select	Select	1	Select

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HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/25/2018	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	11	17	20
Total Met:		20	20	11	17	20
% Compliance:	100%	100%	100%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	N/A	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	N/A	N/A - LOS	Yes
10		Yes	Yes	N/A	Yes	Yes
11		Yes	Yes	N/A	N/A - NLOS	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	N/A	N/A - NLOS	Yes
16		Yes	Yes	N/A	Yes	Yes
17		Yes	Yes	Yes	Yes	Yes
18		Yes	Yes	Yes	Yes	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	Yes	Yes	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	Labs were drawn according to due date of order. Labs are reviewed during chronic care clinic visits. During review, there were some lab results that were not discussed with the patient.						
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	9/27/2018		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		10	10	10	10	8	
% Compliance:	96%	100%	100%	100%	100%	80%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	No	
9		Yes	Yes	Yes	Yes	No	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
Source:	MARS.							
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
Guidelines:								
Remarks:	(b)(6); (b)(7)(C) 18 blanks on MAR							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	9/25/2018				
Facility (f)								
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?		Y					
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?		30					
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?		0					
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.		70					
fMAR-5:	OTCs provided by medical, commissary or both?		Both					
Clinical (c)								
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?							
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
Total Applicable:			3	3				
Total Met:			3	3				
% Compliance:	100%		100%	100%				
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS				
2		11	Yes	Yes				
3		0	N/A - NLOS	N/A - NLOS				
4		1	N/A - LOS	N/A - LOS				
5		1	Yes	Yes				
6		0	N/A - NLOS	N/A - NLOS				
7		18	N/A - NLOS	N/A - NLOS				
8		0	N/A - NLOS	N/A - NLOS				
9		0	N/A - NLOS	N/A - NLOS				
10		3	Yes	Yes				

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MEDICAL RECORD-KEEPING PRACTICES																							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select # files/patients reviewed)		10																					
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.																						
Source:	Medical Records, Chronic Care Log, and MARs.																						
Sample:	10 records of detainees with chronic disease, if available.																						
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."																						
Guidelines:	NCCHC 2014 J-H-01, J-H-03.																						
Remarks:	(b)(6); (b)(7)(C) Type Text Here																						
Reviewer:					**Date Reviewed:**	9/27/2018																	
Facility (f)																							
fMR-1:	Type of Medical Records?		Both																				
fMR-2:	Name of Electronic Health Record?		eCW																				
Total Applicable:		10	10	10	10	10	10	10	10	10	10	10	2	1	10	10	10	10	8	10	10	10	
Total Met:		10	10	10	10	10	10	10	10	10	10	10	2	1	10	10	10	10	8	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	

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MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:	Type Text Here							
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	9/25/2018			
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Total Applicable:		10						
Total Met:		10						
% Compliance:	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		Yes						
3		Yes						
4		Yes						
5		Yes						
6		Yes						
7		Yes						
8		Yes						
9		Yes						
10		Yes						

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	Type Text Here								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/27/2018				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		2				
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	(b)(6); (b)(7)(C) arrived at Adelanto on 9/17/18 +HCG					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	9/24/2018	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Total Applicable:		2	2	1	2	2
Total Met:		2	2	1	2	2
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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SUICIDE SCREENING		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	

Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32
Remarks:	The tool is calculating cSS-5 as 0% however, the findings were 100% that an earlier intervention would not have prevented deterioration to the point of the need for a suicide watch.

Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	9/24/2018

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	51
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			9	10	10	10
Total Met:			9	10	10	0
% Compliance:	75%		100%	100%	100%	0%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	N/A - NLOS	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		At least q 15 min	Yes	Yes	Yes	No
4		At least q 15 min	Yes	Yes	Yes	No
5		At least q 15 min	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		At least q 15 min	Yes	Yes	Yes	No
9		At least q 15 min	Yes	Yes	Yes	No
10		At least q 15 min	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	10/1/2018	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Total Applicable:		10	10	10	0	
Total Met:		10	10	10	0	
% Compliance:	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS	
2		Yes	Yes	Yes	N/A - NLOS	
3		Yes	Yes	Yes	N/A - NLOS	
4		Yes	Yes	Yes	N/A - NLOS	
5		Yes	Yes	Yes	N/A - NLOS	
6		Yes	Yes	Yes	N/A - NLOS	
7		Yes	Yes	Yes	N/A - NLOS	
8		Yes	Yes	Yes	N/A - NLOS	
9		Yes	Yes	Yes	N/A - NLOS	
10		Yes	Yes	Yes	N/A - NLOS	

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	(b)(6); (b)(7)(C) no assessment documented on encounter; (b)(6); (b)(7)(C) no assessment documented on encounter; 213018392 - no RN assesement, referred to provider							
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**	10/1/2018		
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	9	10	6	6	
Total Met:			7	9	9	6	6	
% Compliance:	92%		70%	100%	90%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	rash	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
2		foot pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
3		cough/sore throat	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
4		painful finger	Yes	Yes	Yes	Yes	Yes	
5		pain and numbness to feet and hands	Yes	Yes	Yes	Yes	Yes	
6		headache and back pain	No	Yes	Yes	N/A - NLOS	N/A - NLOS	
7		knee pain	No	Yes	Yes	Yes	Yes	
8		back pain	No	N/A - NLOS	No	Yes	Yes	
9		stomach pain/constipation	Yes	Yes	Yes	Yes	Yes	
10		abdominal pain	Yes	Yes	Yes	Yes	Yes	

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
09/24/2018	03/06/2018	Adelanto ICE Processing Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Los Angeles

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,763	1,517	246	0	2

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
45	21	24	2	1	31

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)	Phone Number: +1 (760) 561-(b)(6); (b)(7)(C)
Address: 10400 Rancho road Adelanto, CA 82301	Address: 10400 Rancho road Adelanto, CA 82301

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Review of the facility's medical care were noted to follow NCCHC, ACA, and PBNDS standards.

Previous Site Visit 03/06/2018
PBNDS 4.3: V.C.2
Tuberculosis Screening Management- Screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.
All new arrivals shall receive TB screening within 12 hours of intake and in accordance with CDC guidelines (www.cdc.gov/tb).

FINDINGS: One out of nineteen (5%) did not have tuberculosis screening completed as per CDC guidelines. One of the detainee's chest x-ray was not read within 72 hours due to "housing issues." The chest x-ray was ordered five days after arrival. The chest x-ray was completed nine days after arrival.

PBNDS 4.3: V.S.4
Sick Call- Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.

This procedure shall include:
an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips

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and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

FINDINGS: Two of three (67%) of the charts reviewed for urgent care (sick call) did not have a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate.

PBNDS 4.3: V.U.5
Medical Care- Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.

FINDINGS: Two of ten (20%) of the charts reviewed indicated that the detainees did not receive their medication within 24-72 hours. One detainee's medication was not ordered at intake because the personal supplies were in Russian, and the nurse could not read them. The detainee went without several cardiac medications for 2-3 days until seen by a provider. In a second detainee, the transfer summary noted a history of asthma, but no medical conditions or medications were documented on the intake screening, and no medications were ordered until the exam 5 days later.

PBNDS 4.8: V.F.4.e
Disability Identification, Assessment, and Accommodation, F4. Multidisciplinary Team, e. Staff Notification- Where an accommodation is granted, facility policy or procedures will ensure that all relevant facility staff, including facility security staff, receive timely notification and, as needed, instructions for successful implementation of the accommodation. These procedures will also account for any applicable privacy and confidentiality considerations.

FINDINGS: Ten detainees were assessed for assistance with activities of daily living (ADL), and appropriate accommodations ordered. Three out of ten (30%) were missing appropriate accommodation orders (Special needs). The facility does not clearly determine in the progress notes if the provider has assessed the detainees for assistance with activities of daily living.

PBNDS 6.2: V.C.4
Medical Grievances- Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale. This record shall be maintained per the following section "D. Record-Keeping and File Maintenance."

FINDINGS: Four out of thirty-six (11%) of the grievances were not addressed within 5 working days of receipt.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
231	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of the facility's medical care were noted to follow NCCHC, ACA, and PBNDS standards.

Previous findings from 03/6/2018 FMC Site Visit

PBNDS 4.3: V.C.4.c - Clinical Evaluation and Management
Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America.

FINDINGS: Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainee was identified on July 20, 2017; however, the chest x-ray was not completed until July 28, 2017. The other

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detainee was identified as being HIV positive on January 31, 2017. The chest x-ray was completed on May 26, 2017.(REPEAT FINDING)

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	3

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were a total of 3 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

Previous findings from 08/29/2017 FMC Site Visit
There were a total of 7 hunger strikes in the last 12 months. A review of the facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	207

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no deficiencies noted regarding this section of the standard. The facility continues to have 2 cells available for suicide watch. Detainees who are determined to be suicidal are evaluated by a mental health provider and are either placed on a constant or staggered (15 minute checks) suicide watch at the facility. If the cells are occupied or if it a serious suicide attempt, the detainee is sent out to the local hospital for further evaluation and treatment.

The facility is now utilizing Anaheim Global Medical Center (AGMC) as the preferred mental health facility. If no beds are available then, Alvarado Parkway Institute (API) is used.

Previous findings from 03/6/2018 FMC Site Visit
There were no deficiencies noted regarding this section of the standard. The facility continues to have 2 cells available for suicide watch. Detainees who are determined to be suicidal are evaluated by a mental health provider and are either placed on a constant or staggered (15 minute checks) suicide watch at the facility. If the cells are occupied or if it a serious suicide attempt, the detainee is sent out to the local hospital for further evaluation and treatment.

The facility continues to utilize the Alvarado Parkway Institute (API) located in San Diego, CA as the preferred inpatient mental health facility.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Previous findings from 03/06/2018 FMC Site Visit
There were no reported deaths, detainees with terminal illness, or detainees with advance directives since the last FMC site visit.

Other Observations

The Adelanto ICE Processing Center (AIPC) IHSC Site visit was conducted September 24, 2018 through October 1, 2018. The site visit was completed by the Los Angeles Field Medical Coordinator. The new Quality of Medical Care (QMC) audit tools were used during the review.

AIPC is a dedicated IGSA with only ICE detainees. AIPC operates under The Geo Group Inc. which contracts with Correct Care Solutions (CCS) to provide on-site medical care. CCS has provided medical care at the facility since March 1, 2016. The facility operates under the 2011 Performance Based National Detention Standards (PBNDS). AIPC received their National Commission on Correctional Health Care (NCCHC) accreditation on April 10, 2016; American Correctional Association (ACA) Accreditation January 23, 2017; Nakamoto Annual Audit scheduled for October 9-11, 2018; and a Disability Rights California (DRC) visit August 13-14, 2018. The facility currently houses approximately 246 female detainees and 1517 male detainees.

AIPC currently utilizes both paper and electronic medical records. AIPC began utilizing eClinical Works (eCW) for their electronic health record on August 30, 2016. Documentation prior to August 30, 2016 remains on paper and documentation following August 30, 2016 is electronic. Medication administration, consents, and refusals are paper records and scanned into the electronic record.

The previous Health Services Administration (HSA) medically retired August 31, 2018. The new

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HSA is a registered nurse and started September 4, 2018. The CCS staffing is currently at 89.5% with 87% supplemental CCS funded staff.

Deficiencies for Areas Evaluated

PBNDS 2011:

No deficiencies were noted.

QUALITY OF CARE

Diabetes:
Six of ten (56%) of detainees did not have aspirin prescribed, as clinically indicated.

Laboratory:
Two of ten (20%) patients who had blood drawn, were not advised of their normal laboratory results.

Sick Call:
Three of ten (30%) charts reviewed for urgent care (sick call) did not have an assessment performed by the registered nurse.

One of the ten (10%) charts reviewed for urgent care (sick call) did not have vital signs documented with the nurse's assessment.

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Suicide Screening

See QCM Tool for current findings

The tool calculated cSS-5 as 0% however, the findings were 100% that an earlier intervention would not have prevented deterioration to the point of the need for a suicide watch.

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Health Assessment

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Urgent Care (Sick Call)

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
One of three (33%) had a nursing referral to a nurse practitioner submitted within 24 hours.

There were no other areas of concern noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QCM Tool for current findings

The tool calculated cEED-2 as 0% however, the findings were 100% that an earlier intervention would not have prevented deterioration to the point of need for ED care.

Previous findings from 03/6/2018 FMC Site Visit
Seven out of nine (78%) of detainees had an inbound progress note and an inbound assessment. Two detainees had no inbound assessment on return from the hospital.

There were no additional areas of concern noted.

Medication Administration Practices

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
One out of two (50%) had an appropriate clinician response.

In one case, a provider acknowledged in an encounter that the nursing staff had informed the provider that a patient was refusing morning insulin, but continued the patient's sliding scale insulin order as twice daily. The printed MAR from CorrectRx for March shows the provider's order for twice daily insulin, but the nursing staff hand-wrote the order on a separate MAR as every evening. There were no signed refusal forms in the patient's chart for insulin in 2018. The nine other charts reviewed yielded a total of 14 refusals or no-shows on

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MARs, of which 2 lacked a signed refusal form. All of these charts showed an appropriate clinician response to consecutive refusals.

Approximately 30% of MARs reviewed had either blanks, consecutive refusals, or no shows. There were no additional areas of concern noted.

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Continuity of Medication

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
Eight of ten (80%) of the charts reviewed indicated that patients are consistently receiving their medication within 24-72hrs. Immediately following the patient's intake encounter, the nurse sends an electronic notification to the provider to order the patients' chronic medications, and the medication is generally received within one business day. One patient's medication was not ordered at intake because his personal supplies were in Russian, and the nurse could not read them. That patient went without several cardiac medications for 2-3 days until he was seen by a provider. In a second patient, the transfer summary noted a history of asthma, but no medical conditions or medications were documented on the intake screening, and no medications were ordered until her exam 5 days later.

There were no additional areas of concern noted.

Mental Health Screen

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Medical Recordkeeping Practices

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
Eight of ten (80%) charts reviewed were in compliance with updating the problem list.

Seven of ten (70%) charts reviewed were in compliance with the receiving screen and health assessment forms. Three of the charts reviewed, the health assessments were not found in the record. East side dental provided an the encounter note that stated dental assessment was completed, but no scanned document of the assessment. The West side clearly does this accordingly, but the East side is not standardized in this procedure.

Eight out of ten (80%) charts reviewed were in compliance with Progress notes. Two of the charts reviewed, the notes were incomplete and not in a SOAP format.

The remaining medical record-keeping practices were in compliance or not applicable.

Pregnant Women

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Dental Care

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit

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There were no areas of concern noted.

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Acute Laboratory Testing

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
Six out of ten (60%) patients had laboratory testing done within one business day of the ordered date or by the due date. There were marked delays, one to two weeks from date desired, in lab drawing of routine labs due to the list being full.

Nine out of ten (90%)patients had clinical acknowledgment of laboratory tests.

One out of ten (10%) patients were advised of laboratory results. There was a trend in lack of documentation of teaching on lab results.

There were no additional areas of concern noted.

Diagnostic Services and Specialty Care Access

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Mental Health Treatment Planning

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
There were no areas of concern noted.

Treatment of Disability

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
Seven out of ten (70%) were assessed for assistance with activities of daily living (ADL), and appropriate accommodations were ordered. Three were missing appropriate accommodation orders (Special needs). The facility does not clearly determine in the progress notes if the provider has assessed if the detainees have been assessed for assistance with activities of daily living. For example, wheel chair bound detainees.

There were no additional areas of concern noted.

Complaints and Grievances

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
32 of the 36 (89%) grievances were found in compliance with PBNDS 2011 of appropriately being addressed within 5 working days of receipt.

The grievance trends identified - 80% were due to delay in care complaints, 10% attitude demeanor or conduct and 10% other.

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There were no additional areas of concern noted.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QCM Tool for current findings

Previous findings from 03/6/2018 FMC Site Visit
Eight out of nine (89%) of detainees had blood sugar measured and recorded on intake.

Nine out of ten (90%) of detainees had a baseline HgbA1c performed within 30 days of intake or within the past 3 months.

Nine out of ten (90%) of detainees were followed at least every 90 days with appropriate vital signs.

Four out of five (80%) of detainees had aspirin prescribed, as clinically indicated.

Nine out of ten (90%) of detainees had the degree of control (goal HgbA1C <8) documented. No issues were identified.

There were no additional areas of concern noted.

Human Immunodeficiency Virus (HIV)

See QCM Tool for current findings

Previous findings from 03/06/2018 FMC Site Visit
Eight out of ten (80%) of detainees had a chest x-ray completed within 72 hours of problem identification, if not already done. In one instance, the detainee was identified on July 20, 2017; however, the chest x-ray was not completed until July 28, 2017. The other detainee was identified as being HIV positive on January 31, 2017. The chest x-ray was completed on May 26, 2017.(REPEAT FINDING)

There were no additional areas of concern noted.

Hypertension

See QCM Tool for current findings

Previous findings form 03/06/2018 FMC Site Visit
Nine of ten (90%) had documented blood pressure reading at intake. One of the detainees did not have a blood pressure reading at intake. The history and physical was completed 2 days after intake and a normal blood pressure reading was recorded.

There were no additional areas of concern noted.

Asthma

See QCM Tool for current findings

Previous findings from 03/06/2018 FMC Site Visit
Eight out of ten (80%) and had a peak flow completed at the initial physical exam. One detainee had an initial exam performed on February 7, 2018, and the peak flow was performed on February 22, 2018. One detainee had an initial exam performed on March 6, 2017, and the peak flow was performed on March 29, 2017. (REPEAT FINDING)

There were no additional areas of concern noted.

Seizure Disorder

See QCM Tool for current findings

Previous findings from 03/06/2018 FMC Site Visit
Four out of six (67%) detainees had appropriate neurological history completed at the initial

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physical examination. Two detainees did not receive a thorough neurological history at the initial exam.

Five out of six (83%) detainees were seen in CCC by mid-level provider or physician within 14 days of illness identification. One detainee was seen in CCC by mid-level at five weeks post illness identification.

There were no additional areas of concern noted.

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Recommendations

(b)(5)

Facility Actions

The Quality Improvement Committee will be adding additional studies to monitor for compliance. The FMC is being invited to attend the quarterly meetings.

CCS implemented new templates for the providers to use to ensure continuity of care and proper documentation.

The facility will be implementing an eMAR system in 2019

Additional Comments

The facility is scheduled for NCCHC audit in February 2019
The facility is scheduled for ACA audit in October 2019

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 809-(b)(6); (b)(7)(C)	Date Prepared: 02/19/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 02/22/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved: 02/27/2019
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Chief, MCMU
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 02/27/2019

Recommendations:

(b)(5)

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ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan
(FMC Site Visit August 2017)

Facility Name **Adelanto Detention Facility**
Address (Street and Name) **10250 Rancho Road**
City, State and Zip Code **Adelanto, CA 92301**
County **San Bernardino**
Date[s] of FMC Follow-up ***30 days of receipt of approved CAP***
Complete and Return to ICE HQ No Later Than: 2/5/2018
Facility Corrective Action Plan Assigned to: AFOD (b)(6); (b)(7)(C)
Date of Final Submission:

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DHS-ICE-20-0618-A-002206

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Site Visit Reviews) Adelanto Detention Facility (LOS AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
Deficiency: PBNDS 4.3.S.4 Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting. Two of ten (20%) of the charts reviewed for urgent care (sick call) did not have timely and appropriate nursing evaluations for the different acute conditions. One detainee was rescheduled for nursing sick call 3 times and	(b)(5)	The findings date back to March and April 2017. Starting on June 1, 2017, on a weekly basis, the HSA has been providing a report of sick call/sick call reschedules to the ICE AFOD. The 2016 PBNDS revisions were discussed during the staff meeting on February 28, 2017. An e-mail to medical staff was sent by the HSA on March 11, 2017 with a copy	Monitoring Reports: On-going Training: Completed on May 15, 2017 CQI Study: Initiated on June 18, 2017 **FMC Update February 2019:**

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another 5 times, which resulted in delay of evaluation and care for 2 weeks for detainees complaining of eye and back pain. The detainee with the complaints of back pain was rescheduled five times before being evaluated. The detainee with the complaints of the eye pain was rescheduled three times before being evaluated. The detainee with the back pain was rescheduled on March 14, March 15, March 16, March 17, March 18 and was eventually evaluated on April 4 during chronic care for the complaint. The detainee with the eye pain was rescheduled on April 16, April 27 and April 28 and was eventually evaluated on April 30. There is no documentation in the medical records regarding why the detainees were rescheduled. One of ten (10%) detainees seen on nursing sick call did not have vital signs documented with the nursing assessment.	(b)(5)	of the revisions to the PBNDS. RN Sick Call 1. The DON scheduled training for all RN's with the eCW Trainer on use of RNSC Nursing Protcols on eCW. The training was completed on May 15, 2017 and reiterated during the staff meeting on June 28, 2017. 2. The DON provided training for all RN's on individualized focused nursing assessment using the established RNSC protocols. This will included taking vital signs at each encounter. The training was completed on May 15, 2017. 3. The DON provided training for all RN's on triage utilizing established guidelines. The training was completed on May 15, 2017. 4. The DON provided training for all RN's on proper scheduling of triaged sick call requests	March 2018 FMC Site Visit compliant for timely evaluation. However, sick call deficiencies related to lack of referral to provider. Please refer to Contract Deficiency Report Update and APIC Response for continued monitoring. **FMC Update February 2019:** FMC Site Visit September 2018 compliant for referral to provider however, with continued sick call deficiencies related to timely evaluation by nurse, and obtaining vital signs. Please refer to Contract

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		to ensure compliance with NCCHC and PBNDS. The training was completed May 15, 2017. Procedure 1. Nurses assigned to the 3rd watch (NOC shift) will collect the sick call requests from the sick call request drop boxes in the units. 2. All sick call requests will be triaged upon receipt. The sick call will be date/time stamped upon receipt. 3. The sick call requests will be scheduled based on urgency. 4. Effective June 1, 2017, all scheduled sick calls are evaluated on the day they are scheduled. The DON reviews the schedule to ensure all sick call request scheduled for the day are completed. In the absence of the DON, the DON will designate a staff to ensure the above is completed.	Deficiency Report Update and APIC Response for continued monitoring.

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		5. Effective June 1, 2017, on a weekly basis, the HSA provides a report of sick call/sick call reschedules to the ICE AFOD. QA and Follow-up 1. On a daily basis, the DON reviews a minimum of 5 RN sick calls to ensure they are properly triaged, scheduled, and evaluated following the established nursing protocols. In the absence of the DON, the DON will designate a reviewer. 2. On a weekly basis, the report of the reviews is forwarded to the HSA and QA for the information to be collated, analyzed, and trended for compliance. The corrective actions will be reviewed if it does not correct the problem. 3. On a quarterly basis, the report of the reviews is presented in the CQI meeting. 4. The study will be conducted until there is a	

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		demonstrated compliance for 90 consecutive days. Attachments: 1 – PBNDS Distribution 2 – Meeting Minutes – Sick Call 3 – Sick Call Report to ICE AFOD 4 – Training on RNSC Protocols 7 – CQI Study – RN Sick Call – Use of Protocols 8 – CQI Study – RN Sick Call – Daily Sick Call Triage and Scheduling	
Deficiency PBNDS 4.3.C.4 Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, The CDC and the Infectious Diseases Society of America. Two of ten (20%) of detainees with HIV did not have a chest x-ray completed within 72 hours of problem identification. For one detainee, the diagnosis was identified on July 29, 2017;	(b)(5)	The health services administrator reviewed policy and CPGs to verify they are in compliance with the CDC guidelines, on January 22, 2018. The medical director distributed the clinical practice guidelines, which comply with CDC guidelines, for management of HIV to clinical staff on January 22, 2018.	Guideline Review: Completed on January 22, 2018 CQI Study: Initiated on June 18, 2017 **FMC February 2019 Update:** FMC March 2018 Site Visit with continued HIV

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however, the chest x-ray was not ordered until August 16, 2017. The other detainee was identified as being HIV positive on September 3, 2016. The chest x-ray was ordered on February 9, 2017, and it was completed on February 10, 2017. (REPEAT FINDING)		Procedure/QA Plan: Chest X-ray Monitoring: 1. All patients received at intake with a diagnosis of HIV are reviewed by the Chronic Care (CC) QA Nurse within 24 hours of arrival. The QA CC nurse will review the intake packet and the USM 533/IHSC 849 transfer sheet to determine if a chest x-ray has been completed prior to arrival. 2. If there is no chest x-ray, a verbal order will be requested from the provider for chest x-ray to be conducted as soon as possible within 72 hours of arrival. 3. The CC QA Nurse will collect the data, aggregate and analyze the data on a weekly basis. 4. The information will be reported to the medical director, HSA and CQI Committee on a weekly basis.	xray deficiencies. **FMC February 2019 Update:** FMC September 2018 Site Visit compliant.

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		5. The review and reporting will be continued until there is a documented compliance for 12 consecutive weeks. Attachments: 5 – HIV Tracking 9 – Clinical Practice Guidelines Distribution	
Quality of Care Best Practice Recommendation: Of the HIV charts reviewed, one of six (16%) detainees was not seen by an HIV or ID specialist within 30 days of HIV identification. The detainee was identified as being diagnosed with HIV on September 3, 2016; however, the detainee was not scheduled for ID visit until December 16, 2016.	(b)(5)	The medical director distributed the clinical practice guidelines, which comply with CDC guidelines, for management of HIV to clinical staff on January 22, 2018. Infectious Disease Referral Procedure: 1. All newly diagnosed HIV patients and newly admitted patients will have laboratory diagnostic studies completed. At the time of diagnosis, the provider will initiate an infectious disease specialist (IDS) referral and advise the medical records scheduler to schedule the	Guideline Review: Completed on January 22, 2018 CQI Study: The study was started on January 22, 2018. **FMC February 2019 Update:** FMC March 2018 Site Visit compliant.

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Quality of Care Issue: One of ten (10%) charts revealed that earlier intervention might have prevented deterioration to the point of need for ED/hospital care. In one case, there was a delay in obtaining a laboratory test. The test was ordered on March 18, 2017; however, it was not obtained until April 3, 2017.	(b)(5)	detainee for an IDS evaluation within 30 days. 2. In the event that a IDS referral could not be scheduled within 30 days of the request, documentation into eCW will be made by the medical records scheduler as to the reason for the ID consult not accomplished within the time frame (ex: ID specialty fully booked, etc.). The medical records scheduler will advise the provider. 3. On a monthly basis, the CC QA nurse will review the records of all HIV patients. The review will follow the clinical practice guidelines to ensure all requirements of the guidelines are being followed (ex: immunizations, diagnostic studies). 4. The CC QA nurse will collect the data, aggregate and analyze the data on a monthly basis. The data will be reported to the medical director, HSA and	

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		CQI Committee on a monthly basis. 5. The CQI study will continue until there is demonstrated compliance of 12 consecutive weeks. The findings date back to March and April 2017. In May 2017 a corrective action plan was initiated which included training for nurses on focused assessments. Laboratory Testing: On December 15, 2017, the tracking process and log for review of laboratory studies was revised. Training: 1. The eCW coordinator will provide training for all providers and laboratory technicians on the standardized way of ordering, reviewing laboratory on eCW. The training will be completed by January 31, 2018. Procedure/QA Follow-up:	Training: Will be completed January 31, 2018. CQI Study: Initiated on January 31, 2018. **FMC February**

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DHS-ICE-20-0618-A-002215

		1. The revised lab log was implemented starting January 1, 2018. The lab log documents the date studies ordered, date drawn, studies, and date results received. 2. On a weekly basis, the AHSA conducts a random sampling of10% of the laboratory studies for review. The review will focus on the timeliness of the laboratory studies performed, in relation to the timeframe the laboratory studies were requested (ex: CBC ordered to be completed within 5 days or next chronic care visit, etc.). 3. The AHSA will report the findings to the QA team on a weekly basis. 4. The QA team will report the findings to the medical director, HSA and CQI committee on a monthly basis. 5. The study will continue until there is a demonstrated compliance	**2019 Update:** FMC March 2018 Site Visit compliant.

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		for a continuous 12 weeks. Attachments: 6 – Lab Reporting Form 9 – Clinical Practice Guidelines Distribution	
Quality of Care Issue: One of ten (10%) of the specialty charts reviewed did not have time urgency documented on the order for specialty care therefore, it could not be verified if the appointment was accomplished within the ordered time frame. One of four (25%) of the specialty charts reviewed did not reveal that the detainee was re-evaluated for deterioration every 30 days until the off-site visit was completed.,. One of the detainees was referred to the ENT on December 29, 2016; the MedPAR was submitted to IHSC on February 21, 2017. There was no documentation in the medical record regarding why there was a delay in submitting the MedPAR. The appointment was completed on March 6, 2017; however, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being	(b)(5)	The medical director distributed the clinical practice guidelines, for the re-evaluation of patients a minimum of every 30 days until the off-site diagnostic services and/or specialty care is completed, on January 22, 2018. On December 15, 2017, the medical director and providers were advised by the HSA to follow-up with patients within 72 hours upon return of patients from hospital or off-site specialty visits. Procedure: On December 15, 2017, a new process of re-evaluation of off-site visits was implemented. A form was developed for the nursing staff to complete upon return	Guideline Review: Completed on January 22, 2018 CQI Study: Initiated on January 15, 2018 **FMC February 2019 Update:** FMC March 2018 Site Visit compliant.

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evaluated at the facility after the ENT appointment. The detainee was released from detention on March 28, 2017. One of ten (10%) specialty charts that was reviewed did not reveal that the clinician acknowledged the specialist's report in the medical record within 7 days of the date the service was performed. One of the detainees was referred to the OB/GYN on February 13, 2017, and the appointment was on March 7, 2017.However, there was no follow-up by the provider after the appointment. The consultation was normal, and there were no recommendations from the consultant. There was no adverse effect noted in the medical record from not being evaluated at the facility after the GYN appointment. Quality of Care Issue: Five of six diabetic charts reviewed showed (90%) of detainees had aspirin prescribed, as clinically indicated. In one instance aspirin was not prescribed as indicated for a 55 year old detainee with hyperlipidemia, hypertension,	(b)(5)	of patients from off-site visits. The nursing staff were advised to schedule the patients for a follow-up visit within 72 hour upon the patients return. QA Monitoring: 1. On a weekly basis, a random review of 5 treatment authorization requests (TAR) will be reviewed by QA nurse to determine the patient has been scheduled and re-evaluated for any condition deterioration. 2. The QA nurse will collect data, aggregate and analyze data and report to the medical director, HSA and CQI committee on a weekly basis. 3. The study will be continued until there is demonstrated continuous compliance for 12 consecutive weeks. 4. Chart reviews of detainees recommended for an off-site consultation/ hospital visit in the past 6 months will be reviewed to verify	

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and positive family history.		the TAR has been completed, and the recommendations were reviewed and addressed by the practitioner. The chart reviews will be conducted by the CC QA Nurse. Diabetes Management: The medical director distributed clinical practice guidelines for diabetes on January 22, 2018. Procedure/QA follow-up: 1. The medical director will perform a random review of 5 diabetics records on a monthly basis. The review will focus on diabetes management based on CPG and the use of aspirin if clinically indicated. 2. The medical director will discuss the findings with the providers as part of the peer review process. 3. The medical director will forward his findings to the CC QA nurse and HSA. 4. The data will be collected,	Guideline Review: Completed on January 22, 2018 CQI Study: Initiated on January 1, 2018 **FMC February 2019 Update:** FMC March 2018 Site Visit noncompliant. **FMC February 2019 Update:** FMC September 2018 Site Visit compliant.

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		aggregated and analyzed and reported on a monthly basis to the CQI committee. 5. The study will be performed until there is a demonstrated continuous compliance for 12 consecutive weeks. Attachments: 9 – Clinical Practice Guidelines Distribution	
Quality of Care Issue: Of the asthma charts reviewed, one of nine (11%) of detainees did not have a peak flow completed at the initial exam. One detainee did not report asthma on intake; however, the medical transfer summary received by Adelanto noted a history of chronic asthma. Therefore, a peak flow should have been performed.	(b)(5)	Peak Flow The medical director distributed clinical practice guidelines on peak flows, to providers, on January 22, 2018. Procedure/QA Plan: 1. All detainees received at intake with a diagnosis of asthma will be scheduled for a provider by the receiving nurse for a chronic care H&P within 48 hours of arrival. 2. The medical transfer summaries will be reviewed thoroughly by	Guideline Reivew: Completed on January 22, 2018 CQI Study: Initiated on January 10, 2018 **FMC February 2019 Update:** FMC March 2018 Site Visit noncompliant. **FMC February 2019 Update:** FMC September 2018 Site Visit

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		the screening nurse and all identified chronic conditions not reported by the detainee on medical screening and identified on the transfer summary will be added to the chronic care H&P. 3. The medical director will perform a random review of detainees received with a diagnosis of asthma as part of the peer review process. 4. The review will be conducted on a monthly basis. The medical director will address non-compliance with the provider. 5. The CC QA nurse will conduct a weekly audit of all detainees received with asthma. The review will focus on the peak flow being performed at the initial visit. On a monthly basis, a review of all detainees with a diagnosis of asthma will be performed by the CC QA Nurse to review if peak	compliant.

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		flows are being conducted on subsequent chronic care visits. 6. The CC QA Nurse will collect the data, aggregate and analyze the data on a weekly/monthly basis. The information will be reported to the medical director, HSA and CQI Committee. 7. The study will continue until there is demonstrated compliance for 12 consecutive weeks. Attachments: 9 – Clinical Practice Guidelines Distribution	

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DHS-ICE-20-0618-A-002222

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Adelanto ICE Processing Center			
AOR:*	LOS			
Address:	10400 Rancho Rd			
City:	Adelanto		**County:**	San Bernardino
State:*	CA	**Zip:**	82301	
Inspection Information				
Start Date:*	12/2/2019			
End Date:*	12/6/2019			
Organization:*		Other		
# Detainees at Time of Visit:		1550		
Total Facility Population at Time of Visit:		1550		
Facility Capacity:		1920		
Notes:	The Adelanto ICE Processing Center (AIPC) is an ICE dedicated IGSA with only detainees. AIPC operates under the GEO Goup Inc which contracts with Wellpath to provide on-site medical care.			
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	3/3/2020
Signature:	Expired certificate X (b)(6); (b)(7)(C) Signed by (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	9	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	100%	
DM	Diabetes	99%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	99%	
HIV	Human Immunodeficiency Virus	84%	
HTN	Hypertension	100%	
LT	Laboratory Testing	98%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	98%	
SS	Suicide Screening	98%	
TD	Treatment of Disability	87%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX							
**1 FTE = 40 hours / per week*							
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**	**Comments**
C.N.A.	(b)(7)(E)						
Dental Assistant							
Dentist							
EMT							
H.S.A.							
LVN/LPN							
MH Counselor							
MRT							
NP/PA							
Nurse Manager							
Paramedic							
Pharmacist							
Pharmacy Tech							
Physician							
Psychiatrist							
Psychologist							
RN							
Social Worker							
X-ray Tech							
Assistant H.S.A.							
DON							
TOTAL							

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	(b)(6); (b)(7)(C) peak flows not completed with each CCC visit; however, was completed within last 3 months (CCC 5/14/19, PF completed; CCC 6/19/19, PF 6/28/19; CCC 8/12/19, PF 10/29/19)							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/2/2019			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		BOP Clinical Practice Guideline					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		10	10	9	10			
Total Met:		10	10	9	10			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	Yes	Yes	Yes			
4		Yes	Yes	Yes	Yes			
5		Yes	Yes	Yes	Yes			
6		Yes	Yes	Yes	Yes			
7		Yes	Yes	Yes	Yes			
8		Yes	Yes	Yes	Yes			
9		Yes	Yes	N/A - LOS	Yes			
10		Yes	Yes	Yes	Yes			

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	11	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	(b)(6); (b)(7)(C) Intake on 9/9/2019, blood sugar obtained 9/11/2019.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 12/2/2019

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP Clinical Practice Guideline

	Clinical (c)
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		10	11	11	11	4	0	11	5
Total Met:		9	11	11	11	4	0	11	5
% Compliance:	99%	90%	100%	100%	100%	100%		100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	No	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	N/A - NLOS
2		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
3		Yes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	N/A - NLOS
4		Yes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	Yes
5		Yes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	N/A - NLOS	
7		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
8		Yes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	N/A - NLOS	
9		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	
10		N/A	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
11		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	

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HIV								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
Guidelines:	National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines http://nccc.ucsf.edu University of California, San Francisco. HIV Clinical Consultation Center. ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
Remarks:	(b)(6); (b)(7)(C) arrived 10/28/19, has not been seen by ID; (b)(6); (b)(7)(C) arrived 3/8/19, seen by ID 5/24/19 (b)(6); (b)(7)(C) newly diagnosed 10/17/19, has not been seen by ID (b)(6); (b)(7)(C) arrived 10/30/2019, has not seen ID; (b)(6); (b)(7)(C) arrived 8/28/19, seen by ID on 10/18/19; (b)(6); (b)(7)(C) arrived 5/13/19, seen by ID 6/21/19; (b)(6); (b)(7)(C) arrived 9/28/19, seen by ID 12/5/18.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/5/2019			
Facility (f)								
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?		BOP Clinical Practice Guideline					
Clinical (c)								
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?							
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
cHIV-4	Was antiretroviral treatment considered and documented?							
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
Total Applicable:			10	9	10	10	9	
Total Met:			10	2	10	10	9	
% Compliance:	84%		100%	22%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	No	Yes	Yes	Yes	
2		Patient Interview	Yes	No	Yes	Yes	Yes	
3		Patient Interview	Yes	Yes	Yes	Yes	Yes	
4		Patient Interview	Yes	Yes	Yes	Yes	Yes	
5		Recent Lab	Yes	No	Yes	Yes	Yes	
6		Patient Interview	Yes	N/A - LOS	Yes	Yes	Yes	
7		Patient Interview	Yes	No	Yes	Yes	Yes	
8		Patient Interview	Yes	No	Yes	Yes	Yes	
9		Patient Interview	Yes	No	Yes	Yes	Yes	
10		Patient Interview	Yes	No	Yes	Yes	N/A - NLOS	

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HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/2/2019		
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?			Y		
fHTN-1b:	If yes, what is the guideline?	BOP Clinical Practice Guideline				
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	10	10	
Total Met:		10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**	
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes	
2		Y	Yes	Yes	Yes	
3		Y	Yes	Yes	Yes	
4		Y	Yes	Yes	Yes	
5		Y	Yes	Yes	Yes	
6		Y	Yes	Yes	Yes	
7		Y	Yes	Yes	Yes	
8		Y	Yes	Yes	Yes	
9		Y	Yes	Yes	Yes	
10		Y	Yes	Yes	Yes	

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~~FOR OFFICIAL USE ONLY (LAW ENFORCEMENT SENSITIVE)~~

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) started on medication 11/5/19; multiple refusals for lab and no documentation regarding discussing importance of labs. (b)(6); (b)(7)(C) reports history of childhood seizures, no seizure for 3 years, refused medication. Low bunk/tier was documented in the note but no chrono was issued (b)(6); (b)(7)(C) new onset seizure 2/2018 due to being hit in the head with a pistol, last seizure 8/2018, last on medications 20/2018					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/6/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP Clinical Practice Guideline				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		10	10	4	10	10
Total Met:		10	10	4	10	9
% Compliance:	98%	100%	100%	100%	100%	90%

Patient(s)	A# (numbers only)	cSZ-1	cSZ-2	cSZ-3	cSZ-4	cSZ-5
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	N/A - NLOS	Yes	Yes
3		Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	Yes	N/A - NLOS	Yes	Yes
5		Yes	Yes	N/A - NLOS	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	N/A - NLOS	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	No

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:	Type Text Here		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/5/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	9
Total Met:		10	9
% Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	N/A - LOS
10		Yes	Yes

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/4/2019			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	8	8			
Total Met:		10	10	8	8			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	N/A - NLOS			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	N/A - NLOS	N/A - NLOS			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	

Purpose:	To assess timeliness of off-site diagnostic services and specialty care.
Source:	Referrals log, medical records or MedPars.
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.
Remarks:	The ordered timeframe is indicated by the end date on the referral date. It is not clear if the end date is recommended by the Medical Director as the end date can be changed by anyone accessing the referral. Recommended for the Medical Director to indicate the ordered timeframe (i.e. 30 days) in the structured date of the referral as was previous practice.

Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/5/2019

Clinical (c)	
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

Total Applicable:			10	9	8	9
Total Met:			10	9	8	9
% Compliance:	100%		100%	100%	100%	100%

Patient(s)	A# (numbers only)	Clinic	cDSA-1	cDSA-2	cDSA-3	cDSA-4
1	(b)(6); (b)(7)(C)	Other	Yes	Yes	N/A - NLOS	Yes
2		Orthopedics	Yes	Yes	Yes	Yes
3		Orthopedics	Yes	Yes	Yes	Yes
4		Other	Yes	Yes	Yes	Yes
5		Orthopedics	Yes	Yes	Yes	Yes
6		Neurology	Yes	Yes	Yes	Yes
7		Other	Yes	Yes	Yes	Yes
8		Orthopedics	Yes	Yes	Yes	Yes
9		Opthalmology	Yes	N/A - LOS	N/A - LOS	N/A - LOS
10		Other	Yes	Yes	Yes	Yes

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.		
Source:	Emergency Department (ED) logs.		
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.		
Guidelines:	NCCHC 2014 J-E-12.		
Remarks:	Type Text Here		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/6/2019

Clinical (c)	
cEED-1	Is there an outbound progress note?
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.
cEED-3	Is there discharge documentation from the hospital or ED in the chart?
cEED-4	Is there an inbound assessment?
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?

Total Applicable:			10	10	10	10	10
Total Met:			10	10	10	10	10
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
1	(b)(6); (b)(7)(C)	abdominal pain	Yes	No	Yes	Yes	Yes
2		abnormal EKG	Yes	No	Yes	Yes	Yes
3		r/o cellulitis	Yes	No	Yes	Yes	Yes
4		r/o CVA vs. TIA	Yes	No	Yes	Yes	Yes
5		severe headache	Yes	No	Yes	Yes	Yes
6		heroin withdrawal	Yes	No	Yes	Yes	Yes
7		abdominal pain	Yes	No	Yes	Yes	Yes
8		chest pain	Yes	No	Yes	Yes	Yes
9		fight	Yes	No	Yes	Yes	Yes
10		fractured tibia	Yes	No	Yes	Yes	Yes

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	9						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	There were several rescheduled appointments during the month of September due to mumps cohort. Several providers did not want to see detainees during the cohort						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/5/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			13			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			13			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	9	0	3	9	0	1	0
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

AMERICAN OVERSIGHT

Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	0	0	2	0	0	0
2		0	0	1	0	0	0
3		0	1	2	0	0	0
4		0	0	2	0	0	0
5		0	0	1	0	0	0
6		0	1	0	0	0	0
7		0	0	0	0	1	0
8		0	0	1	0	0	0
9		0	1	0	0	0	0
10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20	

Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.
Sample:	20 medical records chosen at random.
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
Remarks:	(b)(6); (b)(7)(C) Refused PPD, CXRay ordered but never obtained.
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 12/3/2019

Clinical (c)	
cHA-1	Initial screen complete within 12 hours of booking?
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.

Total Applicable:		20	15	8	20	20
Total Met:		20	14	8	20	20
% Compliance:	99%	100%	93%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	N/A	Yes	Yes
7		Yes	N/A	N/A	Yes	Yes
8		Yes	Yes	N/A	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	N/A	Yes	Yes
11		Yes	N/A	Yes	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	No	N/A	Yes	Yes
14		Yes	N/A	N/A	Yes	Yes
15		Yes	Yes	N/A	Yes	Yes
16		Yes	N/A	N/A	Yes	Yes
17		Yes	Yes	Yes	Yes	Yes
18		Yes	N/A	Yes	Yes	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess timeliness, continuity, and coordination of care.					
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.					
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) thyroid panel drawn 9/9/2019, results not reviewed with the patient.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/2/2019	
Clinical (c)						
cLT-1	Was blood drawn or test done within 1 business day of ordered date?					
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?					
cLT-3	Was there clinical acknowledgment?					
cLT-4	Was there an appropriate clinical response?					
cLT-5	Was patient advised of laboratory results?					
Total Applicable:		9	10	10	10	10
Total Met:		9	10	10	10	9
% Compliance:	98%	100%	100%	100%	100%	90%
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**
1	(b)(6); (b)(7)(C)	N/A	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	No

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
Source:	MARS.							
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
Guidelines:								
Remarks:	MARs are not scanned into eCW. The MARs are available in the sMARt system. Detainees 6, 7 &9: Form would not allow a 0 to be added at the beginning of the A#.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/3/2019			
Facility (f)								
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y			
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				1			
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				99			
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				75			
fMAR-5:	OTCs provided by medical, commissary or both?				Both			
Clinical (c)								
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?							
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
Total Applicable:			1	1				
Total Met:			1	1				
% Compliance:	100%		100%	100%				
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
1	(b)(6); (b)(7)(C)	1	N/A - NLOS	N/A - NLOS				
2		0	N/A - NLOS	N/A - NLOS				
3		2	N/A - NLOS	N/A - NLOS				
4		0	N/A - NLOS	N/A - NLOS				
5		0	N/A - NLOS	N/A - NLOS				
6		0	N/A - NLOS	N/A - NLOS				
7		2	N/A - NLOS	N/A - NLOS				
8		1	Yes	Yes				
9		2	N/A - NLOS	N/A - NLOS				
10		0	N/A - NLOS	N/A - NLOS				

AMERICAN OVERSIGHT

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	Type Text Here
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 12/3/2019

Facility (f)																							
fMR-1:	Type of Medical Records?		Both																				
fMR-2:	Name of Electronic Health Record?		eCW																				
Total Applicable:		10	10	10	10	10	1	10	9	10	6	3	3	6	7	10	10	10	10	10	10	10	10
Total Met:		10	10	10	10	10	1	10	9	10	6	3	3	6	7	10	10	10	10	10	10	10	10
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
8		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
10		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	Type Text Here								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/4/2019				
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	Type Text Here								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	12/4/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

AMERICAN OVERSIGHT

PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		1				
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/2/2019	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Total Applicable:		1	1	0	1	1
Total Met:		1	1	0	1	1
% Compliance:	100%	100%	100%		100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	(b)(6); (b)(7)(C) Q15min checks ordered; up to 18 min between some checks.					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/5/2019		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		42			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Total Applicable:			10	10	10	10
Total Met:			9	10	10	10
% Compliance:	98%		90%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	At least q 15 min	Yes	Yes	Yes	No
2		At least q 15 min	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		At least q 15 min	Yes	Yes	Yes	No
5		At least q 15 min	No	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		At least q 15 min	Yes	Yes	Yes	No
8		At least q 15 min	Yes	Yes	Yes	No
9		At least q 15 min	Yes	Yes	Yes	No
10		At least q 15 min	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	(b)(6); (b)(7)(C) Intake 10/31/18, ADL assessment not complete. (b)(6); (b)(7)(C) Intake 10/26/19, ADL assessment not complete (b)(6); (b)(7)(C) born with deafness to the right ear; problem list not updated to include disability; declined any accomodations. (b)(6); (b)(7)(C) problem list updated to include hearing loss; however, DAN form not in the record						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/5/2019		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		10	10	9	0		
Total Met:		9	7	9	0		
% Compliance:	87%	90%	70%	100%			
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS		
2		Yes	Yes	Yes	N/A - NLOS		
3		Yes	No	Yes	N/A - NLOS		
4		Yes	No	Yes	N/A - NLOS		
5		No	No	N/A - NLOS	N/A - NLOS		
6		Yes	Yes	Yes	N/A - NLOS		
7		Yes	Yes	Yes	N/A - NLOS		
8		Yes	Yes	Yes	N/A - NLOS		
9		Yes	Yes	Yes	N/A - NLOS		
10		Yes	Yes	Yes	N/A - NLOS		

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**	12/5/2019		
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	4	4	
Total Met:			10	10	10	4	4	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	back/knee pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
2		heel pain	Yes	Yes	Yes	Yes	Yes	
3		stomach pain	Yes	Yes	Yes	Yes	Yes	
4		vomiting	Yes	Yes	Yes	Yes	Yes	
5		ear pain	Yes	Yes	Yes	Yes	Yes	
6		headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
7		foot issues	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
8		constipaton	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
9		headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
10		red dot on eye	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Adelanto ICE Processing Center			
AOR:*	LOS			
Address:	10400 Rancho Rd			
City:	Adelanto		**County:**	San Bernardino
State:*	CA	**Zip:**	82301	
Inspection Information				
Start Date:*	5/20/2019			
End Date:*	5/24/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		1810		
Total Facility Population at Time of Visit:		1810		
Facility Capacity:				
Notes:	The Adelanto ICE Processing Center (AIPC) is an ICE dedicated IGSA with only detainees. AIPC operates under The Geo Group Inc. which contracts with Wellpath to provide on-site medical care.			
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	7/9/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	95%	
CG	Complaints and Grievance	15	*Total Number
CM	Continuity of Medications	90%	
DC	Dental Care	100%	
DM	Diabetes	93%	
DSA	Diagnostic Services and Specialty Care Access	90%	
EED	Evaluation of Care Prior to Emergency Department	80%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	96%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	97%	
MAR	Medication Administration Records		
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	95%	
SS	Suicide Screening	75%	
TD	Treatment of Disability	67%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1						
Other 2						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	(b)(6); (b)(7)(C) - new intake on 2/11/19, H&P on 2/26/19 (b)(6); (b)(7)(C) new intake on 3/20/19, H&P on 4/11/19; in Administrative Seg for PC 3/24/19 -3/28/19; in the infirmary on psych observation 3/28/19 - 3/30/19 then back to PC. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/23/2019			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		BOP Clinical Practice Guideline					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		10	10	10	10			
Total Met:		8	10	10	10			
% Compliance:	95%	80%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	Yes	Yes	Yes			
4		No	Yes	Yes	Yes			
5		Yes	Yes	Yes	Yes			
6		Yes	Yes	Yes	Yes			
7		Yes	Yes	Yes	Yes			
8		Yes	Yes	Yes	Yes			
9		Yes	Yes	Yes	Yes			
10		No	Yes	Yes	Yes			

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	(b)(6); (b)(7)(C) arrival date 12/20/2018, blood sugar not measured at intake. (b)(6); (b)(7)(C) arrival date 1/24/2019, HgbA1C performed on 5/15/2019. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/21/2019

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP Clinical Practice Guidelines

Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		9	10	10	10	9	3	10	6
Total Met:		8	10	9	10	9	2	10	6
% Compliance:	93%	89%	100%	90%	100%	100%	67%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	N/A	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
2		No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	No	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS
4		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS
5		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - NLOS

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	
8		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	

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HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	9						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines http://nccc.ucsf.edu						
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	(b)(6); (b)(7)(C) arrived 3/8/19; appointment with ID on 4/24/19; however, provider rescheduled; seen by ID on 5/24/19. (b)(6); (b)(7)(C) arrived 9/28/18; seen by ID on 12/5/18 Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/22/2019		
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP Clinical Practice Guidelines					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			9	9	9	9	9
Total Met:			9	7	9	9	9
% Compliance:	96%		100%	78%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	Yes	Yes	Yes	Yes	
2		Patient Interview	Yes	Yes	Yes	Yes	Yes	
3		Patient Interview	Yes	No	Yes	Yes	Yes	
4		Patient Interview	Yes	Yes	Yes	Yes	Yes	
5		Patient Interview	Yes	Yes	Yes	Yes	Yes	
6		Patient Interview	Yes	No	Yes	Yes	Yes	
7		Patient Interview	Yes	Yes	Yes	Yes	Yes	
8		Patient Interview	Yes	Yes	Yes	Yes	Yes	
9		Patient Interview	Yes	Yes	Yes	Yes	Yes	
10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2019	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		BOP Clinical Practice Guidelines			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	6	10	
Total Met:		10	10	6	10	
% Compliance:	100%	100%	100%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes
2		Y	Yes	Yes	Yes
3		Y	Yes	Yes	Yes
4		Y	Yes	Yes	Yes
5		Y	Yes	N/A - NLOS	Yes
6		Y	Yes	N/A - NLOS	Yes
7		Y	Yes	Yes	Yes
8		Y	Yes	N/A - NLOS	Yes
9		Y	Yes	Yes	Yes
10		Y	Yes	N/A - NLOS	Yes

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) arrived 11/12/18; phenytoin level 11/12/18; refused lab 3/7/19; labs ordered for 6/17/19. (b)(6); (b)(7)(C) - arrived 10/31/18; topiramate level 11/20/18; refused lab 5/14/19; labs ordered for 6/11/19. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP Clinical Practice Guidelines				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		10	10	8	10	10
Total Met:		10	10	6	10	10
% Compliance:	95%	100%	100%	75%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	No	Yes	Yes
3		Yes	Yes	No	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	N/A - LOS	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	N/A - NLOS	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes

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CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:	(b)(6); (b)(7)(C) Metformin 4/1/19 ordered. Given 4/3/19. (b)(6); (b)(7)(C) Amlodipine ordered 4/11/19. Given 4/13/19. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/21/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	10
Total Met:		10	8
% Compliance:	90%	100%	80%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	No
3		Yes	Yes
4		Yes	No
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

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DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	(b)(6); (b)(7)(C) - refused dental treatment, refusal form signed. - refused dental treatment, refusal form signed. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/23/2019			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	10	2			
Total Met:		10	10	10	2			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	N/A - NLOS			
2		Y	Yes	Yes	N/A - NLOS			
3		Y	Yes	Yes	N/A - NLOS			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	N/A - NLOS			
7		Y	Yes	Yes	N/A - NLOS			
8		Y	Yes	Yes	N/A - NLOS			
9		Y	Yes	Yes	N/A - NLOS			
10		Y	Yes	Yes	N/A - LOS			

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.	
Source:	Referrals log, medical records or MedPars.	
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.	
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.	
Remarks:	(b)(6); (b)(7)(C) - referral made 12/10/18 with 30 day timeframe, patient seen 2/1/19 when appt was available. (b)(6); (b)(7)(C) seen by ENT 2/4/29, clinician did not acknowledge report within 7 days in the record. (b)(6); (b)(7)(C) seen by oral surgeon on 2/12/19, no acknowledgement of report in record. (b)(6); (b)(7)(C) referral made for ENT on 2/9/19 with 30 days timeframe; patient had an attorney visit so appointment was rescheduled; patient seen 4/1/19. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/24/2019

Clinical (c)	
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

Total Applicable:			10	10	2	10
Total Met:			10	8	2	8
% Compliance:	90%		100%	80%	100%	80%
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**
1	(b)(6); (b)(7)(C)	Other	Yes	No	Yes	Yes
2		Other	Yes	Yes	N/A - NLOS	No
3		Other	Yes	Yes	N/A - NLOS	No
4		Other	Yes	Yes	N/A - NLOS	Yes
5		Other	Yes	Yes	N/A - NLOS	Yes
6		Other	Yes	Yes	N/A - NLOS	Yes
7		Other	Yes	No	Yes	Yes
8		Other	Yes	Yes	N/A - NLOS	Yes
9		Other	Yes	Yes	N/A - NLOS	Yes
10		Orthopedics	Yes	Yes	N/A - NLOS	Yes

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	Type Text Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.							
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	5/22/2019		
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	0	10	10	10	
% Compliance:	80%		100%	0%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Headache	Yes	No	Yes	Yes	Yes	
2		Abdominal pain	Yes	No	Yes	Yes	Yes	
3		R/O overdose	Yes	No	Yes	Yes	Yes	
4		R/O left knee dislocation	Yes	No	Yes	Yes	Yes	
5		New intake, hx lymphoma	Yes	No	Yes	Yes	Yes	
6		lethargy	Yes	No	Yes	Yes	Yes	
7		Abdominal pain	Yes	No	Yes	Yes	Yes	
8		Altercation	Yes	No	Yes	Yes	Yes	
9		Altered level of consciousness	Yes	No	Yes	Yes	Yes	
10		Abnormal EKG	Yes	No	Yes	Yes	Yes	

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	15						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/24/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			20			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			20			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	15	1	4	3	4	1	7
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	1	Select	Select	Select	Select
2		Select	Select	Select	Select	Select	2
3		Select	Select	1	Select	Select	Select
4		Select	Select	Select	Select	Select	1
5		Select	Select	Select	1	Select	Select
6		Select	Select	Select	1	Select	Select
7		Select	Select	Select	1	Select	Select
8		Select	1	1	1	Select	Select
9		1	Select	Select	Select	Select	Select
10		Select	1	Select	Select	Select	Select
11		Select	Select	Select	Select	Select	3
12		Select	1	Select	Select	Select	Select
13		Select	Select	1	Select	Select	Select
14		Select	Select	Select	Select	1	Select
15		Select	Select	Select	Select	Select	1

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HEALTH ASSESSMENT		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20	

Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.
Sample:	20 medical records chosen at random.
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.

Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/20/2019

Clinical (c)	
cHA-1	Initial screen complete within 12 hours of booking?
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.

Total Applicable:		20	16	16	19	20
Total Met:		20	16	16	19	20
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		Yes	Yes	N/A	N/A - NLOS	Yes
12		Yes	N/A	Yes	Yes	Yes
13		Yes	N/A	Yes	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	N/A	N/A	Yes	Yes
16		Yes	Yes	Yes	Yes	Yes
17		Yes	Yes	Yes	Yes	Yes
18		Yes	Yes	Yes	Yes	Yes
19		Yes	N/A	Yes	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/21/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	8	
Total Met:		10	10	10	10	8	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - NLOS	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	N/A - LOS	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
Source:	MARS.							
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
Guidelines:								
Remarks:	Effective February 2019, the facility started using eSMARt Wellpath's policy is that a provider is notified after three consecutive refusals. A review of this tool revealed that MARs are not available in eCW. The MARs are kept in the sMARt system and not eCW. Only providers and nurses who have access to the sMARt system are able to view the MARs. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/24/2019			
Facility (f)								
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y			
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				1			
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0			
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				70			
fMAR-5:	OTCs provided by medical, commissary or both?				Both			
Clinical (c)								
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?							
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
Total Applicable:			0	0				
Total Met:			0	0				
% Compliance:								
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS				
2		0	N/A - NLOS	N/A - NLOS				
3		0	N/A - NLOS	N/A - NLOS				
4		0	N/A - NLOS	N/A - NLOS				
5		0	N/A - NLOS	N/A - NLOS				
6		0	N/A - NLOS	N/A - NLOS				
7		0	N/A - NLOS	N/A - NLOS				
8		1	N/A - NLOS	N/A - NLOS				
9		0	N/A - NLOS	N/A - NLOS				
10		0	N/A - NLOS	N/A - NLOS				

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MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	MH RHU Rounds Logs not placed in eCW. MH infirmary observation logs not placed in eCW. [redacted] migraines not listed. [redacted] psoriasis not listed. H&P not locked or not performed. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.
Reviewer:	(b)(6); (b)(7)(C)
Date Reviewed:	5/21/2019

Facility (f)		
fMR-1:	Type of Medical Records?	Both
fMR-2:	Name of Electronic Health Record?	eCW

Total Applicable:		10	10	10	10	9	3	9	10	10	5	6	1	6	9	10	10	10	10	10	10	10	10
Total Met:		10	8	10	9	9	2	9	10	10	5	6	1	6	9	10	10	10	10	10	10	10	10
% Compliance:	97%	100%	80%	100%	90%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		Compliant	Compliant	Compliant	Compliant	Compliant	Non-Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6		Compliant	Non-Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
8		Compliant	Non-Compliant	Compliant	Non-Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
9		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
10		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/22/2019					
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).		
Source:	Patients on mental health caseload, including all patients on psychotropic medication.		
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.		
Guidelines:	NCCHC 2014 J-G-04 (Item 2)		
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/22/2019

Clinical (c)			
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?		
cMHT-2	Are treatment plans updated at a minimum of every 90 days?		
Total Applicable:		10	7
Total Met:		10	7
% Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cMHT-1	cMHT-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	N/A - LOS
3		Yes	N/A - LOS
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	N/A - LOS
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

AMERICAN OVERSIGHT

PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		3				
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/22/2019	
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Total Applicable:		3	3	3	3	3
Total Met:		3	3	3	3	3
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

SUICIDE SCREENING		
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	

Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32
Remarks:	Previous findings from 09/24/2018 FMC Site Visit:There were no areas of concern noted.

Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/22/2019

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	39
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			10	10	10	10
Total Met:			10	10	10	0
% Compliance:	75%		100%	100%	100%	0%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	At least q 15 min	Yes	Yes	Yes	No
2		At least q 15 min	Yes	Yes	Yes	No
3		At least q 15 min	Yes	Yes	Yes	No
4		At least q 15 min	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		At least q 15 min	Yes	Yes	Yes	No
7		At least q 15 min	Yes	Yes	Yes	No
8		At least q 15 min	Yes	Yes	Yes	No
9		At least q 15 min	Yes	Yes	Yes	No
10		At least q 15 min	Yes	Yes	Yes	No

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	Clincal notes do not clearly determine if the provider has assessed the detainees for assistance with activities of daily living. Disability Accommodations Notification (DAN) Forms are not being scanned into the medical record. Previous findings from 09/24/2018 FMC Site Visit: There were no areas of concern noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/24/2019	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Total Applicable:		10	5	10	0	
Total Met:		10	0	10	0	
% Compliance:	67%	100%	0%	100%		
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	No	Yes	N/A - NLOS	
2		Yes	No	Yes	N/A - NLOS	
3		Yes	No	Yes	N/A - NLOS	
4		Yes	No	Yes	N/A - NLOS	
5		Yes	No	Yes	N/A - NLOS	
6		Yes	N/A - NLOS	Yes	N/A - NLOS	
7		Yes	N/A - NLOS	Yes	N/A - NLOS	
8		Yes	N/A - NLOS	Yes	N/A - NLOS	
9		Yes	N/A - NLOS	Yes	N/A - NLOS	
10		Yes	N/A - NLOS	Yes	N/A - NLOS	

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	Previous findings from 09/24/2018 FMC Site Visit There were no areas of concern noted.							
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	5/22/2019		
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	8	2	2	
Total Met:			10	10	8	2	2	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Rash	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
2		Stomachache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
3		Multivitamins and Lotion request	Yes	Yes	N/A - NLOS	N/A - NLOS	N/A - NLOS	
4		Headache, Sore throat	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
5		Itching	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
6		Medication refill	Yes	Yes	Yes	Yes	Yes	
7		Knee Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
8		Body Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
9		Radiology results	Yes	Yes	N/A - NLOS	Yes	Yes	
10		Dry painful eyes	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 08/31/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no no If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 40

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	6	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	12	
Delay(s) in care	9	
Competency/professional skillset of medical staff	1	
Attitude, demeanor or conduct of staff	2	
Other	10	
Total	40	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 08/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Gastroenterology	YES	YES	N/A	YES
2		Other	NO	NO	NO	YES
3		OB/Gyn	YES	YES	N/A	NO
4		Neurology	YES	YES	YES	YES
5		Other	YES	YES	N/A	YES
6		Endocrinology	YES	YES	YES	YES
7		Cardiology	YES	YES	N/A	YES
8		Hematology	YES	YES	YES	YES
9		Other	YES	YES	N/A	YES
10		OB/Gyn	YES	YES	N/A	YES
		Total	9 / 10 90 %	9 / 10 90 %	3 / 4 75 %	9 / 10 90 %

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 08/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	20 / 20 100 %	18 / 18 100 %	11 / 11 100 %	20 / 20 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 08/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? BOP hypertension chronic care guideline

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	N/A	YES
4		YES	YES	N/A	YES
5		YES	YES	YES	YES
6		YES	YES	N/A	YES
7		YES	YES	N/A	YES
8		YES	YES	N/A	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002286

LABORATORY TESTING

DATE 08/31/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 8/31/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto Processing Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☐ Electronic ☑ Both Name of Electronic Health Record: Electronic Clinical Works

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	Compliant	NA	NA
Results of specialty consultations and referrals[7]	NA	Compliant	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	Compliant	NA	Compliant	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 8/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☐ Electronic ☑ Both Name of Electronic Health Record: eCW

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	NA	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	NA	Compliant	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	Compliant	Compliant
Discharge summaries from ED and hospitalizations	NA	NA	NA	Compliant	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	Compliant
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	NA	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 08/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised September 2016

AMERICAN OVERSIGHT

INTAKE EVALUATION: PREGNANT WOMEN

DATE 08/29/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES	YES
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	2 /2 100 %	2 /2 100 %	2 /2 100 %	2 /2 100 %	2 /2 100 %	2 /2 100 %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 08/31/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Adelanto ICE Processing Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	YES	NA
6		YES	YES	YES	NA
7		YES	YES	YES	NA
8		YES	YES	YES	NA
9		YES	YES	YES	NA
10		YES	YES	YES	NA
	TOTALS	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	0 / 0 0 %

KEY: NA = not applicable

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 08/30/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Adelanto ICE Processing Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	back pain	NO	YES	YES	N/A	N/A
2		abdominal pain	YES	YES	YES	YES	YES
3		left sided pain	YES	YES	YES	N/A	N/A
4		ear pain	YES	YES	YES	YES	YES
5		eye pain	NO	YES	NO	N/A	N/A
6		chest pain	YES	YES	YES	YES	YES
7		constipation	YES	YES	YES	YES	YES
8		abdominal pain	YES	YES	YES	N/A	N/A
9		abdominal pain/re	YES	YES	YES	YES	YES
10		bloody stool	YES	YES	YES	YES	YES
		Total	8 / 10 80 %	10 / 10 100 %	9 / 10 90 %	6 / 6 100 %	6 / 6 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	NA
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002294

LABORATORY TESTING

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	NA
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	NA	NA	NA	NA	NA
MARs[5]	NA	NA	NA	NA	NA
Lab and diagnostic reports[6]	NA	NA	NA	NA	NA
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

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	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
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Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	NA	NA	NA	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	Compliant	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

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Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	Compliant	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

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Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	NA	NA	NA	NA	NA
MARs[5]	NA	NA	NA	NA	NA
Lab and diagnostic reports[6]	NA	NA	NA	NA	NA
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	Compliant	NA	Compliant
Results of specialty consultations and referrals[7]	Compliant	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	Compliant	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☑ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	Compliant	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES

2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? <5%

3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0

4 Estimate the percentage of patients on self-administered medication ordered by a provider. 25

5 OTCs provided by medical, commissary or both? Both

Item #	Measure
1	What is the number of refusals and/or no shows during the previous month for each patient?
2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	1	NA	NA
2		0	NA	NA
3		1	NA	NA
4		0	NA	NA
5		0	NA	NA
6		0	NA	NA
7		1	NA	NA
8		0	NA	NA
9		0	NA	NA
10		0	NA	NA
	Total		0 /0 NaN%	0 /0 NaN%

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002302

MEDICATION ADMINISTRATION PRACTICES

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? <5%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 30
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	9	YES	YES
2		2	NA	NA
3		1	NA	NA
4		2	NA	NA
5		2	NA	NA
6		1	NA	NA
7		1	NA	NA
8		4	YES	YES
9		0	NA	NA
10		1	NA	NA
	Total		1 /1 100%	1 /1 100%

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? <5
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 30
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	1	NA	NA
2		1	NA	NA
3		0	NA	NA
4		0	NA	NA
5		1	NA	NA
6		1	NA	NA
7		0	NA	NA
8		1	NA	NA
9		2	NA	NA
10		1	NA	NA
	Total		0 /0 NaN%	0 /0 NaN%

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002304

MENTAL HEALTH SCREEN

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		NA
9		NA
10		NA
	Total	7 / 7 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised September 2016

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	NA
2		YES	NA
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	NA
8		NO	NA
9		NO	NA
10		NO	NA
	Total	7 / 7 100 %	4 / 4 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002308

MENTAL HEALTH TREATMENT PLANNING

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	NA
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	9 / 9 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002309

MENTAL HEALTH TREATMENT PLANNING

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	NA
5		YES	NA
6		YES	YES
7		YES	NA
8		YES	NA
9		YES	NA
10		YES	NA
	Total	10 / 10 100 %	4 / 4 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002310

INTAKE EVALUATION: PREGNANT WOMEN

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6	
1	(b)(6); (b)(7)(C)	YES	YES	YES	NO	YES	YES	seen on day 33
2		YES	YES	YES	NA	YES	YES	left after 2 d
3		NA	NA	NA	NA	NO	NO	
4		NA	NA	NA	NA	NO	NO	
5		NA	NA	NA	NA	NO	NO	
6		NA	NA	NA	NA	NO	NO	
7		NA	NA	NA	NA	NO	NO	
8		NA	NA	NA	NA	NO	NO	
9		NA	NA	NA	NA	NO	NO	
10		NA	NA	NA	NA	NO	NO	
	Total	2 /2 100 %	2 /2 100 %	2 /2 100 %	0 /1 0 %	2 /2 100 %	2 /2 100 %	

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

INTAKE EVALUATION: PREGNANT WOMEN

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	NO CHARTS	NA	NA	NA	NA	NO	NO
2	TO REVIEW	NA	NA	NA	NA	NO	NO
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	/ %	/ %	/ %	/ %	/ %	/ %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

INTAKE EVALUATION: PREGNANT WOMEN

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	YES	YES	NO	NA	YES	YES
2		YES	YES	NO	NO	YES	YES
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	2 /2 100 %	2 /2 100 %	0 /2 0 %	0 /1 0 %	2 /2 100 %	2 /2 100 %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Aurora ICE Detention Center			
AOR:*	DEN			
Address:	3130 Oakland St			
City:	Aurora		**County:**	Adams
State:*	CO	**Zip:**	80010	
Inspection Information				
Start Date:*	3/25/2019			
End Date:*	3/28/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		1252		
Total Facility Population at Time of Visit:		1313		
Facility Capacity:		1360		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	4/5/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	13	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	98%	
DM	Diabetes	100%	
DSA	Diagnostic Services and Specialty Care Access	94%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	98%	
HIV	Human Immunodeficiency Virus	75%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records		
MHS	Mental Health Screen	80%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	100%	
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	100%	

AMERICAN OVERSIGHT

IGSA STAFFING MATRIX						
**1 FTE = 40 hours / per week*						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1 AHSA						
Other 2						
TOTAL						

AMERICAN OVERSIGHT

INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene,

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.
- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in
- In most cases, the recommended sample size will provide a reliable picture of care that can be
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq 90\%$. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide

TIPS FOR REVIEWERS

AMERICAN OVERSIGHT

• Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.
• Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.
• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		6						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		Management of Asthma					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		6	6	2	6			
Total Met:		6	6	2	6			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes			
2		Yes	Yes	N/A - LOS	Yes			
3		Yes	Yes	N/A - LOS	Yes			
4		Yes	Yes	N/A - LOS	Yes			
5		Yes	Yes	Yes	Yes			
6		Yes	Yes	N/A - LOS	Yes			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Good practice - excellent Diabetic foot exam form #1,3,4 - new arrival, seen by provider but no follow-up yet.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 3/25/2019

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	GEO policy #606, 606-A. CPG- Management of Diabetes protocol.

Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		10	10	10	10	3	3	10	4
Total Met:		10	10	10	10	3	3	10	4
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - LOS
2		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
3		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - LOS
4		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - NLOS
5		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
7	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - NLOS	
8		Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	
9		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes	
10		Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	N/A - NLOS	

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HIV								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	2							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu					
	University of California, San Francisco. HIV Clinical Consultation Center.							
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
Remarks:	#1- arrived 3/7, HIV 10+ yrs, established medication #2 - arrived 3/7, HIV 26 yrs. The providers follow Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), GEO group clinical practice guidelines and the HIV Medicine Association of the Infectious Disease Society of America to manage HIV detainees.							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/25/2019				
Facility (f)								
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	Management of HIV Infection						
Clinical (c)								
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?							
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
cHIV-4	Was antiretroviral treatment considered and documented?							
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
Total Applicable:			2	2	2	0	2	
Total Met:			2	0	2	0	2	
% Compliance:	75%		100%	0%	100%		100%	
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	No	Yes	N/A - LOS	Yes	

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
2	(b)(6); (b)(7)(C)	Patient Interview	Yes	No	Yes	N/A - LOS	Yes	
3		Select	Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

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HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		Management of Hypertension			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	5	10	
Total Met:		10	10	5	10	
% Compliance:	100%	100%	100%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	Yes
2		Y	Yes	Yes	Yes
3		y	Yes	N/A - NLOS	Yes
4		Y	Yes	N/A - NLOS	Yes
5		y	Yes	N/A - NLOS	Yes
6		Y	Yes	Yes	Yes
7		y	Yes	Yes	Yes
8		y	Yes	N/A - NLOS	Yes
9		y	Yes	Yes	Yes
10		y	Yes	Yes	Yes

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	#1 - refused lab work - changed to lamictal. No seizures 5+yrs					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	Management of Seizure Disorder				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		3	3	2	3	3
Total Met:		3	3	2	3	3
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess timeliness of medication, as ordered.							
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).							
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.							
Guidelines:								
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019			
Clinical (c)								
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?							
cCM-2	Period of time from order to first dose less than 24 hours?							
Total Applicable:		10	10					
Total Met:		10	10					
% Compliance:	100%	100%	100%					
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**					
1	(b)(6); (b)(7)(C)	Yes	Yes					
2		Yes	Yes					
3		Yes	Yes					
4		Yes	Yes					
5		Yes	Yes					
6		Yes	Yes					
7		Yes	Yes					
8		Yes	Yes					
9		Yes	Yes					
10		Yes	Yes					

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DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	#10 - evaluated on day 5 A dentist and dental assistant provide routine dental services at the facility. The dental room has two exam chairs, autoclave instruments and other dental supplies available. The room is kept locked at all times.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	10	10			
Total Met:		10	9	10	10			
% Compliance:	98%	100%	90%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		y	Yes	Yes	Yes			
4		y	Yes	Yes	Yes			
5		y	Yes	Yes	Yes			
6		y	Yes	Yes	Yes			
7		y	Yes	Yes	Yes			
8		y	Yes	Yes	Yes			
9		y	Yes	Yes	Yes			
10		y	No	Yes	Yes			

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:	#2-radiology #6 - order was during government shutdown, was seen w/n 30 days after medpar approved. #7 - oral surgery #8 - left after two weeks, referral was placed. #9 - left 1 week after referral placed (jan 9) #10 - pending surgery, scheduled. DCDC has a contract with Denver Health which has its own designated correctional health care unit. DCDC has access to a full range of specialty services. DCDC has an full time on-site x-ray technician.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019		
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			10	8	2	7	
Total Met:			10	6	2	7	
% Compliance:	94%		100%	75%	100%	100%	
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1	(b)(6); (b)(7)(C)	Cardiology	Yes	Yes	N/A - NLOS	Yes	
2		Other	Yes	Yes	N/A - NLOS	Yes	
3		Other	Yes	Yes	N/A - NLOS	Yes	
4		Other	Yes	Yes	N/A - NLOS	Yes	
5		Infectious Disease	Yes	Yes	N/A - NLOS	Yes	
6		Opthalmology	Yes	No	Yes	Yes	
7		Other	Yes	Yes	N/A - NLOS	Yes	
8		OB/Gyn	Yes	N/A - LOS	N/A - NLOS	N/A - LOS	
9		Neurology	Yes	N/A - LOS	N/A - NLOS	N/A - LOS	
10		General Surgery	Yes	No	Yes	N/A - NLOS	

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019		
		Clinical (c)						
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	shortness of breath	Yes	No	Yes	Yes	Yes	
2		hyperglycemia	Yes	No	Yes	Yes	Yes	
3		Abd pain (cholycystectomy)	Yes	No	Yes	Yes	Yes	
4		neck pain/head injury	Yes	No	Yes	Yes	Yes	
5		testicular pain	Yes	No	Yes	Yes	Yes	
6		r/o seizure	Yes	No	Yes	Yes	Yes	
7		back pain	Yes	No	Yes	Yes	Yes	
8		abd pain	Yes	No	Yes	Yes	Yes	
9		seizures	Yes	No	Yes	Yes	Yes	
10		BLE edema	Yes	No	Yes	Yes	Yes	

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	13						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	1) The Health Services Administrator left at the beginning of March. There was some delay in grievances being answered at that time.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			23			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			19			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	13	0	6	9	1	0	7
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
1	(b)(6); (b)(7)(C)	Select	1	2	Select	Select	Select

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
2	(b)(6); (b)(7)(C)	Select	2	Select	Select	Select	3
3		Select	Select	1	Select	Select	Select
4		Select	Select	Select	Select	Select	1
5		Select	1	1	Select	Select	Select
6		Select	1	Select	Select	Select	Select
7		Select	1	Select	Select	Select	Select
8		Select	Select	1	Select	Select	Select
9		Select	Select	1	Select	Select	Select
10		Select	Select	Select	Select	Select	2
11		Select	Select	1	1	Select	Select
12		Select	Select	Select	Select	Select	1
13		Select	Select	2	Select	Select	Select

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HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	#1 - seen by PA on day 4. #9-seen on day 4.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019	

Clinical (c)	
cHA-1	Initial screen complete within 12 hours of booking?
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.

Total Applicable:		20	20	0	18	20
Total Met:		20	20	0	18	18
% Compliance:	98%	100%	100%		100%	90%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	No
2		Yes	Yes	N/A	Yes	Yes
3		Yes	Yes	N/A	Yes	Yes
4		Yes	Yes	N/A	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	N/A	Yes	Yes
7		Yes	Yes	N/A	Yes	Yes
8		Yes	Yes	N/A	Yes	Yes
9		Yes	Yes	N/A	Yes	No
10		Yes	Yes	N/A	N/A - NLOS	Yes
11		Yes	Yes	N/A	Yes	Yes
12		Yes	Yes	N/A	Yes	Yes
13		Yes	Yes	N/A	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	N/A	Yes	Yes
16		Yes	Yes	N/A	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	N/A - NLOS	Yes
19		Yes	Yes	N/A	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:							
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	3/25/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		10	10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	65							
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
Source:	MARS.							
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
Guidelines:								
Remarks:	The medical department has a wide variety of medications in stock to treat acute and chronic conditions, and it has a contract with Correct Rx pharmacy to supply necessary medications and refills. Correct Rx has a 24-72 hour turnaround on ordered medications. Over the counter (OTC) medications are provided the medical staff and available for purchase at the commissary. fMAR-3: Per the MRT, MARs since the last site visit have been filed in the records on a timely basis. There are still several months from last year that have not been filed.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019			
Facility (f)								
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y			
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				0			
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				4			
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				50			
fMAR-5:	OTCs provided by medical, commissary or both?				Both			
Clinical (c)								
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?							
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
Total Applicable:			0	0				
Total Met:			0	0				
% Compliance:								

Patient(s)	A# (numbers only)	cMAR-1	cMAR-2	cMAR-3
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS
2		0	N/A - NLOS	N/A - NLOS
3		0	N/A - NLOS	N/A - NLOS
4		1	N/A - NLOS	N/A - NLOS
5		0	N/A - NLOS	N/A - NLOS
6		2	N/A - NLOS	N/A - NLOS
7		0	N/A - NLOS	N/A - NLOS
8		0	N/A - NLOS	N/A - NLOS
9		0	N/A - NLOS	N/A - NLOS
10		1	N/A - NLOS	N/A - NLOS

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MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed): 10

Purpose: To assess completeness of the medical record and appropriateness of medical record practices.
Source: Medical Records, Chronic Care Log, and MARs.
Sample: 10 records of detainees with chronic disease, if available.
Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines: NCCHC 2014 J-H-01, J-H-03.

Remarks: MARs were all filed in the charts that were reviewed. However, according to the MRT, there are still several months of unfiled MAR from last year. They have been keeping up with the past few months but have not had a chance to file MARs from last summer/fall. The annex charts had several loose papers in each chart. An additional MRT is being hired for the annex. GEO has selected EMR vendor Spectrum. Spectrum is expected to be coming in April 2019 to install and train staff on the new EMR.

(b)(6); (b)(7)(C)

Reviewer: [redacted] **Date Reviewed:** 3/25/2019

Facility (f)

fMR-1: Type of Medical Records? Paper
fMR-2: Name of Electronic Health Record? Type Text Here

Total Applicable:		10	10	10	10	10	6	10	10	10	4	1	1	10	6	10	10	10	10	10	0	0
Total Met:		10	10	10	10	10	6	10	10	10	4	1	1	10	6	10	10	10	10	10	0	0
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments; known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:	#5 - came with citalopram, still not evaluated by mental health after 1month #7 - no medication, refused appt after referral from intake. #8 - seen on day 27.							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	3/25/2019				
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Total Applicable:		10						
Total Met:		8						
% Compliance:	80%	80%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		Yes						
3		Yes						
4		Yes						
5		No						
6		Yes						
7		Yes						
8		No						
9		Yes						
10		Yes						

AMERICAN OVERSIGHT

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MENTAL HEALTH TREATMENT PLANNING								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).							
Source:	Patients on mental health caseload, including all patients on psychotropic medication.							
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.							
Guidelines:	NCCHC 2014 J-G-04 (Item 2)							
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	3/25/2019			
Clinical (c)								
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?							
cMHT-2	Are treatment plans updated at a minimum of every 90 days?							
Total Applicable:		10	4					
Total Met:		10	4					
% Compliance:	100%	100%	100%					
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**					
1	(b)(6); (b)(7)(C)	Yes	N/A - LOS					
2		Yes	Yes					
3		Yes	Yes					
4		Yes	Yes					
5		Yes	N/A - LOS					
6		Yes	N/A - LOS					
7		Yes	Yes					
8		Yes	N/A - LOS					
9		Yes	N/A - LOS					
10		Yes	N/A - LOS					

AMERICAN OVERSIGHT

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PREGNANT WOMEN						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		1				
Purpose:	To determine compliance with detention standards and continuity and coordination of care.					
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.					
Sample:	10 pregnant detainees, if available.					
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.					
Remarks:	#1 - on PG-4, was not ordered, came with transfer summary and records from previous facility, lab work done the month prior to arrival.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**		3/25/2019
Facility (f)						
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes		
Clinical (c)						
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?					
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?					
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?					
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?					
cPG-5	Were prenatal vitamins prescribed?					
Total Applicable:		1	1	0	0	1
Total Met:		1	1	0	0	1
% Compliance:	100%	100%	100%			100%
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	N/A - NLOS	Yes
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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SUICIDE SCREENING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.						
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32						
Remarks:	#2,3 - except Sunday **Best practice. A Behavior Management Plan (BMP)program was initiated in May 2018. Once a detainee is released from suicide watch, they are followed up daily or weekly based on their mental health needs. The suicide prevention committee meets weekly to discuss patients on the BMP and on active watch. The facility currently does not have mental health coverage on Sundays.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	3/25/2019		
Facility (f)							
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		11				
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y				
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y				
Clinical (c)							
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?						
cSS-2	Were checks documented consistently?						
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?						
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?						
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.						
Total Applicable:			10	10	10	10	
Total Met:			10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**	
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No	
2		Constant (1:1)	Yes	Yes	Yes	No	
3		Constant (1:1)	Yes	Yes	Yes	No	
4		Constant (1:1)	Yes	Yes	Yes	No	
5		Constant (1:1)	Yes	Yes	Yes	No	
6		Constant (1:1)	Yes	Yes	Yes	No	
7		Constant (1:1)	Yes	Yes	Yes	No	
8		Constant (1:1)	Yes	Yes	Yes	No	
9		Constant (1:1)	Yes	Yes	Yes	No	
10		Constant (1:1)	Yes	Yes	Yes	No	

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		2				
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:	#2 - deaf, mute, does not know sign language. New arrival. Trying to set up VTC with family with homemade flash cards. DCDC has special needs equipment available, i.e. handicap cells, wheelchairs, canes, walkers. Detainees with vision and hearing disabilities have access to special services i.e. blind man cane. The facility maintains a list of detainees with disabilities.					
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	3/25/2019	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Total Applicable:		2	2	2	2	
Total Met:		2	2	2	2	
% Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	
3		Select	Select	Select	Select	
4		Select	Select	Select	Select	
5		Select	Select	Select	Select	
6		Select	Select	Select	Select	
7		Select	Select	Select	Select	
8		Select	Select	Select	Select	
9		Select	Select	Select	Select	
10		Select	Select	Select	Select	

AMERICAN OVERSIGHT

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URGENT CARE (SICK CALL)							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.						
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	3/25/2019	
Clinical (c)							
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
cUC-2	Was care delivered within the scope of the nurse's license?						
cUC-3	Were vital signs documented during the nurse's assessment?						
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
Total Applicable:			10	10	10	3	3
Total Met:			10	10	10	3	3
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
1	(b)(6); (b)(7)(C)	cold symptoms	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
2		diet	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
3		ear pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
4		toe issue (diabetic)	Yes	Yes	Yes	Yes	Yes
5		headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
6		eyes burning	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
7		finger/hand pain	Yes	Yes	Yes	Yes	Yes
8		dental pain	Yes	Yes	Yes	Yes	Yes
9		constipation	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
10		headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS

AMERICAN OVERSIGHT

The GEO Group, Inc.

The GEO Group, Inc.
Aurora Detention Center
3130 N. Oakland Street
Aurora, CO 80010

TEL: 303-361-6612
FAX: 303-341-2652
www.geogroup.com

To: LCDR (b)(6); (b)(7)(C), RN, BSN
ICE Health Services Corps
Field Medical Coordinator
Denver Field Office
12445 E. Caley Ave. RM125
Centennial, Colorado 80111

LCDR (b)(6); (b)(7)(C)

Please find our responses to the areas of concern that you expressed during your site visit in March 2019. Although you did not include these concerns in your Uniform Corrective Action Plan request. We felt a need to address your concerns and assure you that they are being address. The issues from your email are listed below with the action being taken by the medical department to resolve each issue.

1. MARs since the last site visit in Nov. 2018 have been filed; However, MARs from 3 - 4 months in 2018 are still pending to be filed. Mental Health Screen:
   - Medical records personnel are actively sorting the MARs for those detainees that are still in custody and those that are no longer in custody. The MARs will then be added to all active detainee charts. Those out of custody will be properly archived.

2. Eight of ten (80%) detainees were seen by mental health within 14 days of arrival.
   - An approval for another psychologist at the GEO Aurora facility has been approved to help with the increase in patient volume. Interviews are under way to source another psychologist to resolve the deficiency.

3. Dental Care: nine of 10 (90%) detainees were evaluated within 48 hours of request.
   - The electronic Sick Call request is helping the healthcare staff to evaluate detainees face-to-face within a 24-hour time frame.

4. HIV: Two detainees were not seen by an ID specialist within 30 days. Both were established HIV patients, 10+yrs of HIV on medications.
   - A change will be made to the TAR submission for those detainees needing to been seen by Infectious Disease. The request will be submitted as urgent within 2 weeks to ensure that detainees needing to be evaluated by Infectious Disease occur within the 30 days.

If you have any further concerns or question please feel free to contact my staff or myself at any time.

Sincerely,

Warden Johnny Choate

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 7

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		N/A	N/A	Constant (1:1)	N/A	N/A
9		N/A	N/A	Constant (1:1)	N/A	N/A
10		N/A	N/A	Constant (1:1)	N/A	N/A
	Total	7 /7 100 %	7 /7 100 %		7 /7 100 %	0 /7 0 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 5

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ☑ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ☑ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		NO	NO	At least q 15 min	NO	NO
6		NO	NO	At least q 15 min	NO	NO
7		NO	NO	At least q 15 min	NO	NO
8		NO	NO	At least q 15 min	NO	NO
9		NO	NO	At least q 15 min	NO	NO
10		NO	NO	At least q 15 min	NO	NO
	Total	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 5

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	NO	Constant (1:1)	YES	NO
5		YES	NO	Constant (1:1)	YES	NO
6		N/A	N/A	Constant (1:1)	N/A	N/A
7		N/A	N/A	Constant (1:1)	N/A	N/A
8		N/A	N/A	Constant (1:1)	N/A	N/A
9		N/A	N/A	Constant (1:1)	N/A	N/A
10		N/A	N/A	Constant (1:1)	N/A	N/A
	Total	5 /5 100 %	3 /5 60 %		5 /5 100 %	5 /5 100 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 4/24/2018 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Denver Contract Detention Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	no new records	YES	YES	NA	NA
2	to review	YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA = not applicable

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 01/22/2018 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Denver Contract Detention Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? YES

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	0 / %

KEY: NA = not applicable

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 6/12/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Denver Contract Detention Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? YES

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	0 / 0 NaN %

KEY: NA = not applicable

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	ear pain	YES	YES	YES	NA	NA
2		cold	YES	YES	YES	NA	NA
3		headache	YES	YES	YES	NA	NA
4		psoriasis	YES	YES	YES	YES	YES
5		headache	YES	YES	YES	NA	NA
6		back pain	YES	YES	YES	NA	NA
7		abd pain	YES	YES	YES	YES	YES
8		tingling in toes	YES	YES	YES	YES	YES
9		knee pain	YES	YES	YES	YES	YES
10		arm infection	YES	YES	YES	YES	YES
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %	5 / 5 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	cold	YES	YES	YES	N/A	N/A
2		finger pain	YES	YES	YES	N/A	N/A
3		generalized pain	YES	YES	YES	N/A	N/A
4		back pain	YES	YES	YES	YES	YES
5		cold	YES	YES	YES	N/A	N/A
6		knee pain	YES	YES	YES	YES	YES
7		constipation	YES	YES	YES	YES	YES
8		constipation	YES	YES	YES	N/A	N/A
9		sore throat	YES	YES	YES	N/A	N/A
10		knee pain	YES	YES	YES	YES	YES
		Total	10 / 10 100%	10 / 10 100%	10 / 10 100%	4 / 4 100%	4 / 4 100%

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002352

URGENT CARE (SICK CALL)

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	SOB	YES	YES	YES	NA	NA
2		rash	YES	YES	YES	NA	NA
3		back pain	YES	YES	YES	NA	NA
4		abd pain	YES	YES	YES	YES	YES
5		painful urination	YES	YES	YES	YES	YES
6		knee pain	YES	YES	YES	YES	YES
7		rash	YES	YES	YES	NA	NA
8		back pain	YES	YES	YES	YES	YES
9		knee pain	YES	YES	YES	YES	YES
10		back pain	YES	YES	YES	YES	YES
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	6 / 6 100 %	6 / 6 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002353

ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit March 2019)

Facility Name: Aurora ICE Processing Center	**Address (Full): 3130 Oakland St**	
Date FMC Initiated Request for UCAP: 4/5/2019	**City: Aurora**	**County: Adams**
Complete and Return to IHSC FMC No Later Than: 5/8/2019	**State: CO**	**Zip Code: 80010**
Name of Facility Staff Assigned to Develop / Oversee Corrective Action Plan: (b)(6); (b)(7)(C) **WR Medical Director,** (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) **RN. QAN,** (b)(6); (b)(7)(C) **Compliance Adminisitrator**		
Date CAP Submitted by Facility: 4/29/2019		
IHSC Approver – Print Name (First, Last): **CAPT** (b)(6); (b)(7)(C)	**Title of IHSC Approver:** **Western Regional Field Medical Coordinator**	
Date CAP Approved by IHSC: **May 30, 2019**		
Signature and Date IHSC Closed Out CAP:	(b)(6); (b)(7)(C) **10/22/2019**	

AMERICAN OVERSIGHT

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Site Visit March 2019) Denver Contract Detention Center (Denver AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
(PBNDS deficiency) Grievances were not consistently answered within five working days. PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable. Repeat Deficiency	On or before April 30, 2019, the HSA or designee will provide refresher training to all clinical staff regarding the PBNDS 6.2 Grievance System and grievance response timeframes. The shift lead nurses are responsible for responding to the grievances. The Acting H.S.A and the Western Regional Director, Medical Compliance are reviewing the grievance responses. All medical grievances are handled through the Telmate Tablet electronic tracking system which records all aspects of the grievance process.	July 1, 2019	During the August 23, 2019 FMC Site Visit, there were no deficiencies found in the audit of greivances.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002355

	All ICE medical grievances are now handled through the Telmate tablet electronic system. The system tracks all asspects of the grievance process. Effective May 1, 2019, the HSA or designee will conduct weekly reviews of all healthcare grievances to verify grievances were addressed within five working days. Any discrepancies will be immediate corrected and addressed with the responsible staff member. The results of monitoring activities will be reported in monthly CQI meetings, and the monitoring will continue until sustained compliance is achieved for 60 consecutive days.		
(PBNDS and NCCHC deficiency) Detainees with chronic medical conditions were not consistently seen by a provider within two working days of arrival. - PBNDS 2011 4.3.J, Where there is a significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening. - NCCHC Standard; J-E-04, Initial Health Assessment. Inmates identified with	On or before April 30, 2019, the HSA or designee will provide refresher training to all clinical staff regarding the PBNDS 2011 4.3.J, NCCHC Standard J-E-04, and new arrivals with chronic conditions being seen by a provider within two working days of arrival. Beginning May 1, 2019, the HSA or designee will review all intake chronic care charts to verify detainees with chronic medical conditions are seen by a provider within two working days of arrival. Any discrepancies will be immediately corrected and addressed with the responsible staff member. The results of monitoring activities will be reported in the monthly CQI meetings, and the	July 1, 2019	During the August 23, 2019 FMC Site Visit, there were no deficiencies found in the audit of chronic medical conditions.

AMERICAN OVERSIGHT

clinically significant findings as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.	monitoring will continue until sustained compliance is achieved for 60 consecutive days.		

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002357

ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit November 2018)

Facility Name: Aurora ICE Processing Center	**Address (Full): 3130 Oakland St**	
Date FMC Initiated Request for UCAP: 2/5/2019	**City: Aurora**	**County: Adams**
Complete and Return to IHSC FMC No Later Than: 3/5/2019	**State: CO**	**Zip Code: 80010**
Name of Facility Staff Assigned to Develop / Oversee Corrective Action Plan: Health Services Administrator (b)(6); (b)(7)(C) **Quality Assurance Nurse** (b)(6); (b)(7)(C) **Compliance Administrator** (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)		
Date CAP Submitted by Facility: February 28, 2019		
IHSC Approver – Print Name (First, Last): CAPT (b)(6); (b)(7)(C)	**Title of IHSC Approver: Western Regional Field Medical Coordinator**	
Date CAP Approved by IHSC: March 4, 2019		
Signature and Date IHSC Closed Out CAP: (b)(6); (b)(7)(C)		

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Site Visit Novermber 2018) Denver Contract Detention Center (Denver AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
(PBNDS deficiency) Grievances were not consistently answered within five working days. PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.	Effective January 1, 2019, all grievances are submitted and processed electronically via the Telmate electronic tablet system. Medical grievances submitted by detainees are sent directly to the medical unit electronically. The health services administrator (HSA) and the on-duty charge nurse are responsible to review and address medical grievances on a daily basis. Effective January 1, 2019, on a weekly basis the	August 23, 2019	FMC Audit and Site Visit completed August 23, 2019 15 of 15 grievances were auditted from April til present and all were 100% compliant with standard.

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	compliance administrator will randomly review medical grievances to verify they were responded to within 5 working days. Any discrepancies will be reported to the warden. The monitoring will continue until sustained compliance is achieved for 60 consecutive days.		

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002360

ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit January and April 2018)

Facility Name: Denver Contract Detention Center
Address (Street and Name): 3130 N. Oakland St
City, State and Zip Code: Aurora, CO 80010
County: Adams
Date[s] of FMC Site Visit: January 22-24, 2018
Complete and Return to ICE HQ No Later Than: March 16, 2018
Facility Corrective Action Plan Assigned to: (b)(6); (b)(7)(C) **Health Services Administrator, and** (b)(6); (b)(7)(C) **Compliance Administrator**
Date of Final Submission: April 23, 2018

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002361

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Site Visit Reviews) Denver Contract Detention Center (Denver AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
1. (PBNDS deficiency) Physical exams were completed greater than 14 days after arrival.	(b)(5)	On January 2, 2018, a part-time physician assistant was hired to supplement healthcare staffing. One of the primary duties of physician assistant is to assist healthcare staff with completing comprehensive health assessments on detainees within 14 days of arrival or sooner. As of March 3, 2018, the backlog was brought current and all detainees are being seen	June 30, 2018

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		within the required timeframe. A new health services administrator was also hired and entered on duty on March 5, 2018. On March 21 & 22, 2018, GEO's Chief Medical Officer (CMO) will provide training to the facility's medical director and the new, part-time physician's assistant. Beginning on March 15, 2018, 25 detainee medical charts will be reviewed by the HSA/designee at 30, 60, and 90 days to validate compliance with established protocols. Results of the study will be reported at monthly CQI meetings until 3 months of consecutive compliance is maintained.	
2. (PBNDS/NCCHC deficiency) Physical exams for detainees identified as having a chronic disease were completed greater than two working days after arrival.	(b)(5)	On January 2, 2018, a part-time physician assistant was hired to supplement healthcare staffing. One of the primary duties of physician assistant is to assist the physician with completing comprehensive health assessments on detainees with chronic conditions within 2 days of arrival or sooner. As	June 30, 2018

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	(b)(5)	of March 3, 2018, the backlog was brought current and all detainees are being seen within the required timeframe. A new health services administrator was also hired and entered on duty on March 5, 2018. On March 21 & 22, 2018, GEO's Chief Medical Officer (CMO) will provide training to the facility's medical director and the new, part-time physician's assistant. Beginning on March 15, 2018, 25 detainee medical charts will be reviewed by the HSA/designee at 30, 60, and 90 days to validate compliance with the established protocols. Results of the study will be reported at monthly CQI meetings until 3 months of consecutive compliance is maintained.	
3. (PBNDS deficiency) Grievances were not consistently answered within five working days. Repeat finding.		On March 15, 2018, the recently hired HSA provided education and training to the health care staff shift leads on grievance processing. When the HSA is not available a designee will be identified to manage grievances. In order	June 30, 2018

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	(b)(5)	to provide additional support to the new HSA or the designee, beginning on March 15, 2018, the compliance administrator will conduct weekly reviews of the medical grievance log to monitor approaching deadlines and compliance with established protocols. Results of the weekly reviews will be reported at monthly CQI meetings until 3 months of consecutive compliance is maintained. Attachments: 1 – Grievance Training 4 – Staff Training PowerPoint	
4. (PBNDS/NCCHC deficiency) Current staffing was not sufficient, resulting in standards not being met.		In January 2018, the regional health services manager, in conjunction with the human resources manager began interviewing for vacant health services positions. (b)(7)(E) (b)(7)(E)	June 30, 2018

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	(b)(5)	(b)(7)(E)	
5. (Quality of Care) HIV/ID Consults were not initiated on HIV positive detainees.		On March 15, 2018, the recently hired HSA provided education and training to health care staff related to HIV positive detainees and referral to the Infectious Disease/HIV specialist within the required time frame. Beginning on March 16, 2018, 10% of HIV medical charts will be reviewed by the HSA/designee at 30, 60, and 90 days to	June 30, 2018

AMERICAN OVERSIGHT

		determine compliance with established protocols. Results of the study will be reported at monthly CQI meetings until 3 months of consecutive compliance is maintained. Attachments: 2 – HIV Training 4 – Staff Training PowerPoint	
6. (Quality of Care) Detainees with diabetes were not consistently followed every 90 days for chronic care.	(b)(5)	On March 15, 2018, the recently hired HSA provided education and training to health care staff related to IDDM/NIDDM detainee arrival, referral to Chronic Disease Management, and follow up prior to the 90-day requirement. Beginning on March 16, 2018, 10% of diabetic medical charts will be reviewed by the HSA/designee at 30, 60, and 90 days to determine compliance with established protocols. Results of the study will be reported at monthly CQI meetings until 3 months of consecutive compliance is maintained.	June 30, 2018

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		Attachments: 3 – Communicable Diseases Training 4 – Staff Training PowerPoint	

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ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit June 2017)

Facility Name: Denver Contract Detention Center
Address (Street and Name): 3130 N. Oakland St
City, State and Zip Code: Aurora, CO 80010
County: Adams
Date[s] of FMC Site Visit: June 12-14, 2017
Complete and Return to ICE HQ No Later Than: August 25, 2017

Facility Corrective Action Plan Assigned to (b)(6); (b)(7)(C) ***Compliance Administrator and*** (b)(6); (b)(7)(C) ***Health Services Administrator***
Date of Final Submission:

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Site Visit Reviews) Denver Contract Detention Center (Denver AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
(PBNDS deficiency) PBNDS 2011 Medical Care 4.6.D Detainees on suicide watch did not have consistent documentation on a daily basis by a qualified mental health provider.	(b)(5)	On June 21, 2017, the HSA provided training during the medical staff meeting regarding the requirement for all detainees who are placed on suicide watch to be re-evaluated by appropriately trained and qualified medical staff on a daily basis and to document this in the detainee's medical record. Only the mental health professional, clinical medical authority, or designee may	Training: 6/21/2017 Monitoring: 9/21/2017

AMERICAN OVERSIGHT

		terminate a suicide watch after a current suicide risk assessment is completed. The HSA (weekdays), MD (in the HSA's absence), or Nursing Shift Leads (weekends)will review the medical observation record on a daily basis while the patient is on suicide precautions for the next 90 days to verify compliance with daily rounds. Non-compliant findings will be addressed with the responsible staff member and the results of the review will be reported at the quarterly Performance Improvement/Risk Management Meeting. Supporting Documentation: Meeting Minutes -Suicide Watch Daily Visits	
(Quality of Care) Suicide watch nursing assessments were not documented on a daily basis.	(b)(5)	On June 21, 2017, the HSA provided training to all nursing and medical records staff regarding the requirement for all detainees on suicide precautions to be checked at least every 8 hours by clinical staff, and documented in the	Training: June 21, 2017 Monitoring: September 21, 2017

AMERICAN OVERSIGHT

		patient file. The HSA (weekdays), MD (in the HSA's absence), or Nursing Shift Leads (weekends) will review the medical observation record on a daily basis while the patient is on suicide precautions for the next 90 days to verify compliance with rounds. Non-compliant findings will be addressed with the responsible staff member and the results of the review will be reported at the quarterly Performance Improvement/Risk Management Meeting. Supporting Documentation – Suicide Watch Nursing Assessments	
(PBNDS deficiency) Grievance System 6.2 V.4 Grievances were not consistently answered within five working days.	(b)(5)	As of July 24, 2017, the Programs Manager in coordination with the HSA has revised the grievance collection process, allowing for a smoother and quicker allocation of grievances for response. On July 31, all Shift Leads were notified of the change in process and their responsibilities. By August 15,	Process Change: July 31, 2017 Training: 8/15/2017

AMERICAN OVERSIGHT

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	(b)(5)	2017, the HSA will provide training to the medical Shift Leads and assign grievance responses to the Shift Leads duties in the absence of the HSA. Beginning on August 15, 2017, the HSA will provide copies of grievance initial response to the CA for 60 days to confirm the new processes is effective and meets required timeframes. Supporting Documentation – Email direction to the Shift Leads.	
(Quality of Care) OB/GYN Consults were not initiated on pregnant females.		On July 31, 2017, Local Operating Procedure (LOP) 621-B has been revised and submitted for approval to Corporate. The following verbiage was added to page 2 section E "All pregnant females be referred to an OB specialist within seven days of arrival and evaluated by OB specialist within 30 days of arrival and every 30 days or more frequent as required by pregnancy status." The Medical staff will receive training on the policy change	Training: August 30/2017 Monitoring: November 30, 2017

AMERICAN OVERSIGHT

		at the next medical staff meeting scheduled for August 30, 2017. Beginning on August 30, 2017, the HSA will monitor each pregnant female case for the initial evaluation and referral and then weekly thereafter for a period of 90 days to confirm compliance and will report findings at the quarterly Performance Improvement/Risk Management Meeting. Supporting Documentation - (Revised LOP 621-B , Doc-U-Sign Summary showing LOP 621-B has been sent for signatures. Memorandum regarding medical staff training and Chief Medical Practitioner being made aware of requirement.	

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002374

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? CHP

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	NO	NA	NA
2		YES	NO	YES	YES
3		YES	YES	YES	YES
4		YES	NA	NA	NA
5		NA	NA	NA	NA
6		NA	NA	NA	NA
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	3 / 3 100 %	1 / 3 33.33333 %	2 / 2 100 %	2 / 2 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 1/22/18 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? GEO Group

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		NO	YES	YES	YES
3		NO	YES	NA	YES
4		NO	YES	YES	YES
5		NO	YES	YES	YES
6		NO	YES	NA	YES
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	1 / 6 17 %	6 / 6 100 %	4 / 4 100 %	6 / 6 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? GEO Group

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		NA	NA	NA	NA
6		NA	NA	NA	NA
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? CHP

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	No new	NA	NA	NA	NA	NA
2	charts since	NA	NA	NA	NA	NA
3	last site visit	NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	/ NaN%	/ NaN%	/ NaN%	/ NaN%	/ NaN%

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002378

CHRONIC DISEASE – SEIZURE DISORDER

DATE 1/22/18 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? GEO Group

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		NA	NA	NA	NA	NA
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002379

CHRONIC DISEASE – SEIZURE DISORDER

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? GEO GROUP

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	NO CHARTS	NA	NA	NA	NA	NA
2	TO REVIEW	NA	NA	NA	NA	NA
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	/ NaN%	/ NaN%	/ NaN%	/ NaN%	/ NaN%

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002380

COMPLAINTS AND GRIEVANCES

DATE 3/29/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no no If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 24

What percentage of this number were appropriately addressed within 5 working days of receipt? 92 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	2	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	6	
Delay(s) in care	10	
Competency/professional skillset of medical staff	3	
Attitude, demeanor or conduct of staff	1	
Other	2	
Total	24	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 1/22/18 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no yes If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 28

What percentage of this number were appropriately addressed within 5 working days of receipt? 96 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)		
Denial or refusal of specific request(s) for care	1	(b)(6); (b)(7)(C)
Delay(s) in care	16	
Competency/professional skillset of medical staff	1	
Attitude, demeanor or conduct of staff	3	
Other	7	
Total	28	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no no If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 17

What percentage of this number were appropriately addressed within 5 working days of receipt? 82 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	5	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	8	
Delay(s) in care	0	
Competency/professional skillset of medical staff	2	(b)(6); (b)(7)(C)
Attitude, demeanor or conduct of staff	1	
Other	1	
Total	17	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATION

DATE 04/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002384

CONTINUITY OF MEDICATION

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002385

CONTINUITY OF MEDICATION

DATE 06/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002386

Reset Form | Email Form | Print Form

DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
11/13/2018	04/24/2018	Denver Contract Detention Center (DCDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
882	802	80	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
9	5	4	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)	Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)
Address: 3130 Oakland St. Aurora, CO 80010	Address: 3130 Oakland St. Aurora, CO 80010

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Site visit findings 11/13/2018. 23 of 27 (85%) grievances were answered within 5 working days. - PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable. Repeat finding.

Chronic Care

Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.

Total number with chronic conditions:	Total number with unstable chronic conditions:
68	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 605-A Continuity of Care, 603-A Access to Care, 607-Therapuetic Diets

The Clinical Director (CD) developed a new chronic care tracking system which identifies initial appointment dates, last CCC appointment dates, next CCC appointment date, as well as other pertinent information.
All chronic care patients were noted to be identified and screened appropriately during intake. All were referred to the providers appropriately. GEO group chronic care guidelines are based on the Bureau Of Prisons guidelines.
Last site visit: no deficiencies noted

AMERICAN OVERSIGHT

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 614-A Hunger Strike

Previous site visit findings 4/24/2018: No deficiencies noted.

Current site visit findings 11/13/2018: No deficiencies noted.

Review of the facility's hunger strike policy noted to follow NCCHC and PBNDS standards. A review of both medical records showed appropriate care and documentation.

AMERICAN OVERSIGHT

Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	14

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 907-C Suicide prevention and intervention.

Previous site visit findings 4/24/2018: No deficiencies noted.

Current site visit findings 11/13/2018: No deficiencies noted.

Review of 10 suicide watch medical records since last site visit noted to comply with PBNDS standards. All were placed on 1:1 constant watch and every 15 minute documentation of patient observation was noted in the medial charts. Review of medical staff training records had required suicide prevention and intervention documentation. DCDC does not currently have mental health coverage on Sundays.
**Best practice. A Behavior Management Plan (BMP) program was initiated in May 2018. Once a detainee is released from suicide watch, they are followed up daily or weekly based on their mental health needs. The suicide prevention committee meets weekly to discuss patients on the BMP and on active watch.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of a Inmate/Detainee/Resident, 210-Notification in Emergency or Death.

Previous site visit findings 4/24/2018: No deficiencies noted.

Current site visit findings 11/13/2018: No deficiencies noted.

There has not been any detainee deaths since the previous site visit.

Other Observations

The FMC conducted this site visit on November 13-16, 2018. A total of 67 charts and 105 Medication Administration Records (MARs) were reviewed for this audit.

--FACILITY DATA:
- DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 1,100 detainees. The current ICE contract allows 928 ICE detainees.

--ACCREDITATIONS/INSPECTIONS:
- ACA - November 2016.
- PBNDS (Nakamoto Group)- September 2017.
- Office of Detention Oversight (ODO) - January 2018.
- IHSC Investigative Unit, Mortality review. - January 2018.
- PREA Audit - April 2018, DOJ
- GEO Corporate Audit - June 2018
- Civil Right and Civil Liberties - August 2018
- PREA Audit - October 2018, DHS
- NCCHC - October 2018
- OIG - November 2018

--MEDICAL STAFFING:
See QMC toolkit

AMERICAN OVERSIGHT

--STAFFING VACANCIES:
(b)(7)(E)

--MEDICAL CLINIC
- The medical clinic has eight medical housing unit rooms, five negative pressure rooms, and one suicide observation room. (b)(7)(E)
- There is a designated trauma/urgent care room which contains a urgent response cart, three AEDs, two gurneys, an eye wash shower, and other emergency supplies.

--STAFF TRAINING:
- DCDC HSA conducts monthly staff meeting and training. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. Training topics were reviewed and align with accreditation standards.

--SUPPLEMENTAL INFO:
- DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation was noted in non-English speaking charts.
- DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines. The HSA stated that the state of Colorado has the Corporate Practice of Medicine Law which says the physician's clinical judgment is to be followed. Meaning the physician may deviate from the guidelines if, in their clinical judgment, it is best for the patient.

Deficiencies for Areas Evaluated

Site visit findings 11/13/2018. 23 of 27 (85%) grievances were answered within 5 working days.
- PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
Repeat finding.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Health Assessment

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Urgent Care (Sick Call)

See QMC toolkit

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Medication Administration Practices

See QMC toolkit.

The medical department has a wide variety of medications in stock to treat acute and chronic conditions, and it has a contract with Correct Rx pharmacy to supply necessary medications and refills. Correct Rx has a 24-72 hour turnaround on ordered medications. Over the counter (OTC) medications are provided the medical staff and available for purchase at the commissary.

The FMC found <5% of the MARs to have blanks. The HSA was notified, the MARs were corrected and the offending nurse was educated.
There were three months of MARs waiting to be filed in charts of detainees who have left the facility. Active charts were up to date.

AMERICAN OVERSIGHT

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

AMERICAN OVERSIGHT

Continuity of Medication

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Mental Health Screen

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Medical Recordkeeping Practices

See QMC toolkit.

Medical records are located in a secured medical records room in filing cabinets. Medical record files are organized in specific sections within the chart that allows for easy navigation of the file. Detainees with chronic illnesses are in a red chart and separate from other medical records.
DCDC has a target date of April 2019 for an electronic health record.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Pregnant Women

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: (Quality of care finding) One pregnant detainee was not seen by OB/GYN within 30 days. The detainee was seen on day 60. The MedPAR/referral was placed within 2 days of arrival; however, the consulting office rescheduled the appointment.

Dental Care

See QMC toolkit.

A dentist and dental assistant provide routine dental services at the facility. The dental room has two exam chairs, autoclave instruments and other dental supplies available. The room is kept locked at all times.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

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Acute Laboratory Testing

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Diagnostic Services and Specialty Care Access

See QMC toolkit.

DCDC has a contract with Denver Health which has its own designated correctional health care unit. DCDC has access to a full range of specialty services.
DCDC has an full time on-site x-ray technician.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Mental Health Treatment Planning

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Treatment of Disability

See QMC toolkit.

DCDC has special needs equipment available, i.e. handicap cells, wheelchairs, canes, walkers. Detainees with vision and hearing disabilities have access to special services i.e. blind man cane. The facility maintains a list of detainees with disabilities.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Complaints and Grievances

See QMC toolkit.

Previous site visit findings 4/22/18: 22 of 24 grievances were answered within five working days.
Current site visit findings 11/13/18: 24 of 27 grievances were answered within five working days.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Human Immunodeficiency Virus (HIV)

See QMC toolkit.

The providers follow Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), GEO group clinical practice guidelines and the HIV Medicine Association of the Infectious Disease Society of America to manage HIV detainees.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: One detainee was not seen by an ID specialist within 30 days.

Hypertension

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

Asthma

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: Peak flows were not done consistently during the physical exam. Peak flows that were not done at the initial physical exam were completed at the initial CCC appointment, done within 30 days of admission.

Seizure Disorder

See QMC toolkit

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: No findings noted.

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Recommendations

(b)(5)

Facility Actions

1) Staffing: (b)(7)(E)

(b)(7)(E)

3) MARs: The HSA stated multiple trainings have been conducted on this issue. The HSA had the offending nurse correct the MAR and was reeducated on the matter the same day.
4) HIV: The CD stated he will ensure ID consults are done for all ID patients.

Additional Comments

1) Many positives were noted during the site visit, they include; CCC tracker, addition of QA/QI nurse, Behavior management plans, peer review program and overall documentation.

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (720) 873-(b)(6); (b)(7)(C)	Date Prepared: 11/28/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 12/06/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 12/13/2018

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
04/24/2018	01/22/2018	Denver Contract Detention Center (DCDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
794	730	64	1	2

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
9	7	2	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739- (b)(6); (b)(7)(C)	Phone Number: +1 (303) 739- (b)(6); (b)(7)(C)
Address: 11901 East 30th Avenue Aurora, CO 80010	Address: 11901 East 30th Avenue Aurora, CO 80010

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

-Previous site visit findings 1/22/2018:
PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: 22 of 24 grievances were answered within five working days. However, 100% of grievances filed since the new HSA was hired were addressed within five working days. The two that were not was prior to the HSA being hired and were answered on day 7 and 8. (REPEAT)

STAFFING. (b)(7)(E)

(b)(7)(E)

PBNDS Standard Medical Care 4.3 L. Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
CURRENT FINDINGS: Physical examinations were performed within 14 days on 100% of charts reviewed.(RESOLVED)

-Current site visit 4/28/2018:
One standards deficiency noted in regards to responses to grievances within 5 working days - 22 of 24 met criteria, as noted above. However, 100% met since new H.S.A. hired in March 2018.

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
54	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 605-A Continuity of Care, 603-A Access to Care, 607-Therapuetic Diets

Previous site visit findings 6/12/2017:
NCCHC J-E-04 Initial Health Assessment. Inmates identified with clinically significant findings as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.
CURRENT FINDINS: Physical examinations were done within 14 days of the detainee's arrival. Detainee's with chronic illnesses were done within two working days. (RESOLVED)

**The new clinical director (CD) evaluated all but five chronic care detainees within the first month of her arrival to establish a baseline. The remaining five were scheduled for the present week.
The GEOtrack system was being updated during the site visit. This system allows medical staff to schedule, track and identify chronic care patients.
All chronic care patients were noted to be identified and screened appropriately during intake. All were referred to the providers appropriately. GEO group chronic care guidelines are based on the Bureau of Prisons guidelines.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 614-A Hunger Strike

Previous site visit findings 1/22/2018: No deficiencies noted.

Current site visit findings 4/24/2018: No deficiencies noted.

Review of the facility's hunger strike policy noted to follow NCCHC and PBNDS standards.
A review of the medical record showed appropriate care and documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	7

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 907-C Suicide prevention and intervention.

Previous site visit findings 1/22/2018: No deficiencies noted.

Current site visit findings 4/24/2018: No deficiencies noted.

Review of 7 suicide watch medical records since last site visit noted to comply with PBNDS standards. All were placed on 1:1 constant watch, and every 15 minute documentation of patient observation was noted in the medial charts. Review of medical staff training records had required suicide prevention and intervention documentation. DCDC does not currently have mental health coverage on Sundays.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of a Inmate/Detainee/Resident, 210-Notification in Emergency or Death.

Previous site visit findings 1/22/2018: No deficiencies noted.

Current site visit findings 4/24/2018: No deficiencies not

There have been no detainee deaths since the previous site visit.

Other Observations

The FMC conducted this site visit on April 24-26, 2018. This site visit was in response to the findings of the previous site visit from January 24-26, 2018. The FMC was accompanied by another FMC, CDR (b)(6); (b)(7)(C) A total of 56 charts were reviewed for this audit. DCDC uses paper medical records.

--FACILITY DATA:
- DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 1,100 detainees. The current ICE contract allows 928 ICE detainees. The facility has 64 U.S. Marshals detainees at the present time.

--ACCREDITATIONS/INSPECTIONS:
- PBNDS (Nakamoto Group) September 26-28, 2017. All standards were met, no deficiencies.
- ACA November 14-16, 2016. All ACA standards were met, and no deficiencies were noted.
- IHSC January 18-19, 2018. Mortality review.
- Office of Detention Oversight (ODO) inspection - January 8-12, 2018.

--MEDICAL STAFFING:

(b)(7)(E)

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(b)(7)(E)

--VACANCIES:
(b)(7)(E)

--VACANCY UPDATE (6/6/2018)
(b)(7)(E)

--MEDICAL CLINIC
- The medical clinic has eight medical housing unit rooms, five negative pressure rooms, and one suicide observation room. (b)(7)(E)
- There is a designated trauma/urgent care room which contains a urgent response cart, three AEDs, two gurneys, an eye wash shower, and other emergency supplies.

--STAFF TRAINING:
- DCDC HSA conducts monthly staff meeting and training. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. GEO policy only mandates that the medical staff conducts emergency response training annually. The new HSA stated she plans to revamp staff training. Training topics were reviewed and align with accreditation standards.

--SUPPLEMENTAL INFO:
- DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation was noted in non-English speaking charts.
- DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines. The HSA stated that the state of Colorado has the Corporate Practice of Medicine Law which says the physician's clinical judgment is to be followed. This means the physician may deviate from the guidelines if, in their clinical judgment, it is best for the patient.

Deficiencies for Areas Evaluated

-Previous site visit findings 1/22/2018:
GRIEVANCES. PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: 22 of 24 grievances were answered within five working days. However, 100% of grievances filed since the new HSA was hired were addressed within five working days. The two that were not were prior to the HSA being hired and were answered on day 7 and 8. (REPEAT)

STAFFING. PBNDS Standard Medical Care 4.3 V. B. Designation of Authority. All facilities shall provide medical staff and sufficient support personnel to meet these standards.
CURRENT FINDINGS: (b)(7)(E)

(b)(7)(E)

PHYSICAL EXAMS. PBNDS Standard Medical Care 4.3 L. Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
CURRENT FINDINGS: Physical examinations were done performed within 14 days on 100% of charts reviewed. (RESOLVED)

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PHYSICAL EXAMS. NCCHC J-E-04 Initial Health Assessment and PBNDS 2011 Medical Care Medical and Mental Health Screening of New Arrivals. Inmates identified with clinically significant findings as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.
CURRENT FINDINGS: Physical examinations were done within 14 days of the detainee's arrival. Detainee's with chronic illnesses were done with two working days. (RESOLVED)

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Seven charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area. DCDC policy reviewed; 907-C Suicide prevention and intervention. 616-B Mental Health Screening, Evaluation and Services.

1. Seven of seven (100%) suicidal patients were evaluated by a mental health professional within 24 hours.
2. Seven of seven (100%) evaluated daily by a qualified mental health professional.
3&4. Seven of seven (100%) were on continuous watch monitoring and/or every 15 minute watch with checks documented.
5. Seven of seven (100%) did not have evidence that earlier intervention would have prevented the suicide watches.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Health Assessment

20 detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policies reviewed; 601-A Physicals and Health Assessments, 615-B Intake Screening.

1. 20 of 20 (100%) had initial screenings that were completed within 12 hours of arrival.
2. 20 of 20 (100%) received tuberculosis (TB) screening in accordance with requirements.
3. Three of three (100%) were referred for evaluation who screened positive for mental illness or suicide risk.
4. Three of three (100%) had timely follow up of a chronic condition.
5. 20 of 20 (100%) received a complete health evaluation within 14 days of booking.

Previous site visit findings 1/22/2018: Physical examinations were not routinely done within 14 days of the detainee's arrival.

Current site visit findings 4/24/2018: No findings noted.

Two charts reviewed for chronic care showed detainees had intakes done 13 hours after arrival. These appear to be isolated incidents from the previous Friday night in which the facility received 104 intakes.

Urgent Care (Sick Call)

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 625-Sick Call and Triaging of Non-Emergent Request for Health Services; GEO Request for Health Services Form HS-154.

1. Ten of ten (100%) had timely and appropriate evaluation by nursing staff.
2. Ten of ten (100%) received care within the scope of the nurse's license.
3. Ten of ten (100%) had vital signs documented during the nurse's assessment.
4. Five of five (100%) patients were appropriately referred within 24 hours of initial sick call assessment to an MD/PA/NP/DMD.
5. Five of five (100%) patients referred had an MD/PA/NP/DMD assessment and plan documented.

Detainees submit sick call request through a kiosk located in each dorm. Sick call requests are reviewed and triaged by the nurse within 24 hours.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Six detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

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DCDC policies reviewed; 608-B Emergency Services Patient Transport, 613-A Hospitalizations.

1. Six of six (100%) had an outbound progress note.
2. Six of six (100%) did not have evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.
3. Six of six (100%) had discharge documentation from the hospital or ED in the chart.
4. Six of six (100%) had an inbound assessment documented.
5. Six of six (100%) had an inbound assessment reflecting hospital findings and concurrence or deviation from hospital recommendations.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Medication Administration Practices

Ten detainee charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area. 45 Medication Administration Record (MAR) were reviewed from the April MAR binder.

DCDC policies reviewed; 710-Medication Administration, 405-A Medication Administration Training.

No MARs were found to have 3 or more missed doses or refusals.

The medical department has a wide variety of medications in stock to treat acute and chronic conditions, and it has a contract with Correct Rx pharmacy to supply necessary medications and refills. Correct Rx has a 24-72 hour turnaround on ordered medications. Over the counter (OTC) medications are provided the medical staff and available for purchase in the commissary.

The MARs from the previous month have already been filed in the charts; the FMC did not find any unfiled MARs in the medical records filing area. An estimated 25% of detainees are currently on self-administered medications that have been ordered by a physician.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

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Continuity of Medication

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 710-Medication Administration, 615-B Intake Screening.

1. Ten of ten (100%) had medications ordered in less than 24 hours from intake screening.
2. Ten of ten (100%) had the first dose of medication within 24 hours of order.

During the intake screening process, the nurses contact the provider to initiate chronic care (CC) medications.

**Good practice. A review of one chart showed the detainee could not remember the names of his medication but could remember his pharmacy. The nurse called the pharmacy and verified the medications.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Mental Health Screen

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed: 616-A Mental Health Screening, Evaluation and Services.

1. Seven of seven (100%) detainees that had a positive screen for mental illness were referred for evaluation and were seen within a timely manner.

Current processes in place indicated no mental health referral issues during this review.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Medical Recordkeeping Practices

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed: 301- Access to Storage and Confidentiality of Health Records.302-Charting in Health Records.

Medical records are located in a secured medical records room in filing cabinets. Medical record files are organized in specific sections within the chart that allows for easy navigation of the file. Detainees with chronic illnesses are in a red chart and separate from other medical records.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Pregnant Women

Two charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policy reviewed; 621-A Pregnancy Management.

1. Two of two (100%) had pregnancy test performed during intake screening.
2. Two of two (100%) demonstrated proper care of pregnancy test prior to x-ray or before initiation of medications.
3. Two of two (100%) had an OB doctor consult within 7 days of confirmation.
4. Zero of one (0%) were seen by OB within 30 days of confirmation. One detainee left after two days. The other detainee was seen by OB on day #33.
5. Two of two (100%) had screening for HIV, STI, and hepatitis. One had the test ordered, but not completed due to only being the facility for a couple days.

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6. Two of two (100%) had prenatal vitamins prescribed. Health assessments included female specific items as per standards.

Per GEO policy, all female detainees receive a urine pregnancy test during intake assessment. The intake assessment includes an additional page for females that include questions about number of pregnancies, last menstrual period, last sexual intercourse.

Previous FMC site visit from 6/12/2017: Zero of two pregnant detainee had OB/GYN consult initiated. No new pregnant detainees during 1/22/2018 site visit.

Current site visit findings: Both charts had an OB consult initiated within 7 days.

Dental Care

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 101-Dental Treatment Priorities, 102-Oral Care

1. Ten of ten (100%) were screened for symptoms during intake process.
2. Ten of ten (100%) were evaluated by a qualified health professional within 48 hours of request.
3. Ten of ten (100%) had dental clinical notes describing findings, diagnosis, treatment and plans.
4. Five of five (100%) had follow-up treatment as recommended.

A dentist and dental assistant provide routine dental services on Monday through Thursday of each week at the facility. The dental room has two exam chairs, autoclave instruments and other dental supplies available. The room is kept locked at all times.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

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Acute Laboratory Testing

Five charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policy reviewed; 1003-A Diagnostic Services
1. Five of five (100%) had blood drawn or test done within one business day of ordered date.
2. Five of five (100%) had report back within 24 hours.
3. Five of five (100%) had clinical acknowledgment.
4. Five of five (100%) had appropriate clinical response.
5. Five of five (100%) patients were advised of lab results.

DCDC uses Labcorp for all laboratory services. They were having problems with labs being sent and printed multiple times, but the HSA stated the issues have been resolved.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Diagnostic Services and Specialty Care Access

Four charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 1003-Diagnostic Services, 211-Off site hospital and specialty care, 214-A referrals, outside medical care.

1. Four of four (100%) had a documented time urgency included in the order.
2. Four of four (100%) were completed within the time specified or 45 days, and the majority were completed within 14 days.
3. One of one (100%) was re-evaluated for deterioration at least every 30 days until off-site service provided.
4. Four of four (100%) were reviewed by the clinician within seven days.

DCDC has a contract with Denver Health which has its own designated correctional health care unit in the hospital. When specialty care is needed, the CD contacts the Denver Health care coordinator to schedule the appointment. DCDC has access to a full range of specialty services.
DCDC has an full time on-site x-ray technician.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Mental Health Treatment Planning

Seven detainee charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 623-Psychiatric Evaluation

1. Seven of seven (100%) had a clinical assessment, treatment and follow-up plan documented.
2. Four of four (100%) had treatment plans which were updated at least every 90 days. The other three patients have been at the facility less than 90 days.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Treatment of Disability

There were no new disability charts for review since the last site visit

DCDC policies reviewed; 901-B Aids to Impairment (Special Needs and Services), 906-Special Needs Inmate/Detainee.

DCDC has special needs equipment available, i.e. handicap cells, wheelchairs, canes, walkers.

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Detainees with vision and hearing disabilities have access to special services i.e. blind man cane. The facility maintains a list of detainees with disabilities.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Complaints and Grievances

24 charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 205-Grievances

There was a total of 24 medical grievances in the past three months.
Two for availability of care.
Six for denial/refusal of specific request for care.
Ten for delays in care.
Three for competency/professional mindset of medical staff.
One for attitude, demeanor or conduct of staff.
Two classified as other.
22 of 24 charts (92%) were addressed in writing by the HSA within five working days. However, 100% of grievances filed since the new HSA was hired were addressed within five working days. The two that were not were addressed by the previous HSA and were answered on day 7 and 8.

Previous site visit findings 1/22/18: 27 of 28 grievances were answered within five working days. One was answered on day 7.
Current site visit findings 4/22/18: 22 of 24 grievances were answered within five working days. (REPEAT)

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

One charts was reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 606-A Diabetes Mellitus Management

1. One of one (100%) had blood sugar measured and recorded on intake.
2. One of one (100%) were seen for chronic care within fourteen days of illness identification.
3. One of one (100%) had a baseline HgbA1c performed within 30 days of intake or within the past 3 months.
4. One of one (100%) had lipids measured within one year.
5. One of one (100%) were followed at least every 90 days with appropriate vital signs. Five diabetic charts that arrived prior to the January 2018 site visit were also reviewed, and all five were seen for chronic care.
6. One of one (100%) had aspirin prescribed as clinically indicated.
7. One of one (100%) had degree of control documented.
8. One of one (100%) had a documented strategy to attain diabetes control.

The facility uses GEO and the Bureau of Prisons (BOP) clinical guidelines.

Previous FMC site visit from 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.
Current site visit findings 4/24/2018: Initial physical exam was performed within 2 working days of arrival.

Human Immunodeficiency Virus (HIV)

There were no new HIV records for review since the last site visit.

DCDC policy review; 511-A HIV Prevention and Management

The providers follow Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), GEO group clinical practice guidelines and the HIV Medicine Association of the Infectious Disease Society of America to manage HIV detainees.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

Hypertension

Four charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Hypertension.

1. Four of four (100%) had blood pressure reading documented during intake.
2. Four of four (100%) were evaluated by an MD/PA/NP within 14 days of illness identification.
3. One of one (100%) was noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.
4. Four of four (100%) were treated under a chronic disease guideline which included baseline laboratory testing.

Previous FMC site visit from 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.
Current site visit findings 4/24/2018: Initial physical exams were performed within 2 working days of arrival.

Asthma

Three charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

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DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Asthma.

1. Three of three (100%) were seen in the chronic care clinic within 14 days of illness identification.
2. One of three (33%) had documented peak flow measurements during the initial physical exam.
3. Two of two (100%) had documented peak flow measurements during the last chronic care visit or within the last 3 months.
4. Two of two (100%) were treated under a chronic disease guideline which addressed disease severity, prescription of medications consistent with severity and documented degree of control.

The CD stated she was aware that the PA was not doing peak flows at the initial physical exam and stated she has already corrected the problem. The latest arrival did have a peak flow done at the initial physical exam.

Previous FMC site visit from 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.
Current site visit findings 4/24/2018: Initial physical exams were performed within 2 working days of arrival.

Seizure Disorder

There were no new seizure charts for review since the last site visit.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Seizures.

Previous FMC site visit from 1/22/2018: No findings noted.

Current site visit findings 4/24/2018: No findings noted.

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Recommendations

(b)(5)

Facility Actions

(b)(7)(E)

2) Eleven new computers were installed in medical clinic and intake areas. This currently allows easier access to GEOtrack and will facilitate electronic medical records in the future.
3) The HSA stated a process will be developed to document the pre-screens.
4) During the site visit, the HSA was drafting an inventory list for the emergency bag.
5) Based on the CAP response from the January 2018 site visit, the compliance administrator will conduct weekly reviews of the medical grievance log to monitor approaching deadlines and compliance with established protocols. This had an estimated completion date of June 30, 2018.

Additional Comments

1) GEO Corporate had a team on-site conducting a 100% chart review to ensure signatures, documentation and filing were up to date.
2) Please see the Supplemental Criteria Site Visit Review attachment that addressed findings from the IHSC mortality review.

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End of Report

IHSC, Field Medical Coordinator	
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Phone Number: +1 (720) 873-(b)(6); (b)(7)(C)	Date Prepared: 05/14/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 05/15/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved: 06/06/2018
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Unit Chief, Medical Case Management
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 06/06/2018

Recommendations:

(b)(5)

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Reset Form | Email Form | Print Form

DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
01/22/2018	06/12/2017	Denver Contract Detention Center (DCDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
744	717	27	1	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
16	8	8	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)	Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)
Address: 11901 East 30th Avenue Aurora, CO 80010	Address: 11901 East 30th Avenue Aurora, CO 80010

Medical Care

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☒ 3 Standards ☐ >3 Standards

Description of deficiencies:

-Previous site visit findings 6/12/2017:
PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: Repeat deficiency. 27 of 28 grievances were answered within 5 working days. One grievance was answered on day seven.

--Current site visit findings 1/22/2018:
-PBNDS Standard Medical Care 4.3 L. Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
CURRENT FINDINGS: Physical examinations were not routinely done within 14 days of the detainee's arrival.
-PBNDS Standard Medical Care 4.3 V. B. Designation of Authority. All facilities shall provide medical staff and sufficient support personnel to meet these standards.

(b)(7)(E)

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Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
52	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 605-A Continuity of Care, 603-A Access to Care, 607-Therapuetic Diets

Previous site visit findings 6/12/2017: No deficiencies noted.

Current site visit findings 1/22/2018:
NCCHC J-E-04 Initial Health Assessment and PBNDS 2011 Medical Care Medical and Mental Health Screening of New Arrivals. Inmates identified with clinically significant findings as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.
CURRENT FINDINS: Physical examinations were not routinely done within two days of the detianee's arrival for those with chronic care or other medical conditions. Medications and lab work were ordered; however, physical exams for the chronic care patients were delayed by several weeks.

The medical clinic has a designated chronic care registered nurse (RN) who oversees scheduling of chronic care clinic appointments, off site referrals, updating physician orders and working along side the physician. All chronic care patients were noted to be identified and screened appropriately during intake. All were referred to the providers appropriately. GEO group chronic care guidelines are based on the Bureau Of Prisons guidelines.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 614-A Hunger Strike

Previous site visit findings 6/12/2017: No deficiencies noted.

Current site visit findings 1/22/2018: No deficiencies noted.

Review of the facility's hunger strike policy noted to follow NCCHC and PBNDS standards. A review of the medical record showed appropriate care and documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	5

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
DCDC policy reviewed; 907-C Suicide prevention and intervention.

Previous FMC site visit from 6/12/2017:
PBNDS 2011 Medical Care 4.6.D Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record.
CURRENT FINDINGS: Review of medical records revealed evaluation and assessments were documented on a daily basis.

Current site visit findings 1/22/2018: No deficiencies noted.

Review of 4 suicide watch medical records since last site visit noted to comply with PBNDS standards. All were placed on 1:1 constant watch and every 15 minute documentation of patient observation was noted in the medial charts. Review of medical staff training records had required suicide prevention and intervention documentation.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of a Inmate/Detainee/Resident, 210-Notification in Emergency or Death.

Previous site visit findings 6/12/2017: No deficiencies noted.

Current site visit findings 1/22/2018: No deficiencies noted.

There has been one detainee death in the past 12 months. The detainee was a 64 year old male with a long history of heroin and methadone abuse. He was at DCDC for 15 days and was being treated for methadone withdrawal. The official autopsy report is still pending.
IHSC performed a mortality review on January 18-19, 2018. Office of Detention Oversight (ODO) also conducted an investigation in Jan. 2018. The ODO and IHSC investigative reports are pending.
The local policies are in compliance with the PBNDS 2011 standard.

Other Observations

The FMC conducted this site visit on January 22-25, 2018. A total of 63 charts were reviewed for this audit. DCDC uses paper medical records.

--FACILITY DATA:
- DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 1,100 detainees. The current ICE contract allows 928 ICE detainees. The facility has 71 U.S. Marshall detainees at the present time.

--ACCREDITATIONS/INSPECTIONS:
- PBNDS (Nakamoto Group)September 26-28, 2017. All standards were met, no deficiencies.
- ACA November 14-16, 2016. All ACA standards were met, and no deficiencies were noted.
- IHSC January 18-19, 2018. Mortality review. Report is pending.
- ODO January 2018. Mortality review. Report is pending.
- NCCHC due in May 2018

--MEDICAL STAFFING:

(b)(7)(E)

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(b)(7)(E)

--VACANCIES:
(b)(7)(E)

--MEDICAL CLINIC
- The medical clinic has eight medical housing unit rooms, five negative pressure rooms, and one suicide observation room. (b)(7)(E)
- There is a designated trauma/urgent care room which contains an urgent response cart, three AEDs, two gurneys, an eye wash shower, and other emergency supplies.

--STAFF TRAINING:
- DCDC HSA conducts monthly staff meeting and training. Meeting minutes were reviewed. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. GEO policy only mandates that the medical staff conducts emergency response training annually. The HSA reported quarterly man down drills for every shift. Recent man down drill with after actions report provided to FMC for review.
- (b)(7)(E) staff personnel files reviewed. All licensed personnel files had current up to date licenses to practice in the state of Colorado. All had up to date BLS certification.
- DCDC Emergency Medical Services and First Aid policies reviewed; 1004-Emergency Medications and First Aid Kits, 608-A Emergency Services. Correctional staff receives appropriate training. DCDC policy reviewed; 409-A Training, Correctional officers.

--SUPPLEMENTAL INFO:
- DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation was noted in non-English speaking charts.
- DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines. The HSA stated that the state of Colorado has the Corporate Practice of Medicine Law which says the physician's clinical judgment is to be followed. Meaning the physician may deviate from the guidelines if, in their clinical judgment, it is best for the patient.

Deficiencies for Areas Evaluated

-Previous site visit findings 6/12/2017:
PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: 27 of 28 grievances were answered within 5 working days. One grievance was answered on day seven.

-Current site visit findings 1/22/2018:
PBNDS Standard Medical Care 4.3 L. Each facility's health care provider shall conduct a

AMERICAN OVERSIGHT

comprehensive health assessment, including a physical examination and mental health screening on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
CURRENT FINDINGS: Physical examinations were not routinely done within 14 days of the detainees' arrival.

-PBNDS Standard Medical Care 4.3 V. B. Designation of Authority. All facilities shall provide medical staff and sufficient support personnel to meet these standards.

(b)(7)(E)

NCCHC J-E-04 Initial Health Assessment and PBNDS 2011 Medical Care Medical and Mental Health Screening of New Arrivals. Inmates identified with clinically significant findings as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.
CURRENT FINDINGS: Physical examinations were not routinely done within two days of the detainees' arrival for those with chronic care or other medical conditions. Medications and lab work were ordered; however, physical exams for the chronic care patients were delayed by several weeks.

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Suicide Screening

Four charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area. DCDC policy reviewed; 907-C Suicide prevention and intervention. 616-B Mental Health Screening, Evaluation and Services.

1. Four of four (100%) suicidal patients were evaluated by a mental health professional within 24 hours.
2. Four of four (100%) evaluated daily by a qualified mental health professional.
3. Four of four (100%) were on continuous watch monitoring and/or every 15 minute watch with checks documented.
4. Zero of four (0%) had evidence that earlier intervention would have prevented the suicide watches.

Previous FMC site visit from 06/12/2017: PBNDS 2011 Medical Care 4.6.D Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record. CURRENT FINDINGS: Review of medical records revealed evaluation and assessments were documented on a daily basis.

There have been five suicide watches since the last audit. Documentation of continuous patient observation and/or every 15 minute observation was noted in the medical charts. The intake assessment includes the asking of suicide attempts and for current suicidal ideation.

Health Assessment

20 detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policies reviewed; 601-A Physicals and Health Assessments, 615-B Intake Screening.

1. 20 of 20 (100%) had initial screenings that were completed within 12 hours of arrival.
2. 20 of 20 (100%) received tuberculosis (TB) screening in accordance with requirements.
3. Three of three (100%) were referred for evaluation who screened positive for mental illness or suicide risk.
4. Seven of nine (78%) had timely follow up of a chronic condition.
5. 13 of 20 (65%) received a complete health evaluation within 14 days of booking.

RNs are trained and signed off by the CD to conduct physical exams. All detainees noted to have chronic care diagnosis will be referred to the mid level provider or CD for further evaluation.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: Physical examinations were not routinely done within 14 days of the detainee's arrival. Detainees with a chronic condition did not have timely follow-up.

Urgent Care (Sick Call)

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 625-Sick Call and Triaging of Non-Emergent Request for Health Services; GEO Request for Health Services Form HS-154.

1. Ten of ten (100%) had timely and appropriate evaluation by nursing staff.
2. Ten of ten (100%) received care within the scope of the nurse's license.
3. Ten of ten (100%) had vital signs documented during the nurse's assessment.
4. Four of four (100%) patients were appropriately referred within 24 hours of initial sick call assessment to an MD/PA/NP/DMD.
5. Four of four (100%) patients referred had an MD/PA/NP/DMD assessment and plan documented.

Detainees submit sick call request through a kiosk located in each dorm. Sick call request are reviewed and triaged by the nurse within 24 hours.

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Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Five detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policies reviewed; 608-B Emergency Services Patient Transport, 613-A Hospitalizations.

1. Five of five (100%) had an outbound progress note.
2. Five of five (100%) did not have evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.
3. Five of five (100%) had discharge documentation from the hospital or ED in the chart.
4. Five of five (100%) had an inbound assessment documented.
5. Five of five (100%) had an inbound assessment reflecting hospital findings and concurrence or deviation from hospital recommendations.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Medication Administration Practices

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area. 40 Medication Administration Record (MAR) were reviewed from the January MAR binder.

DCDC policies reviewed; 710-Medication Administration, 405-A Medication Administration Training.

1. One of one (100%) had documentation that the prescribing clinician was notified of consecutive refusals.
2. One of one (100%) had an appropriate response from the clinician.

One medical record noted that the detainee refused the medication four times; however, the medication refusals did not meet the tool's threshold. The medical department has a wide variety of medications in stock to treat acute and chronic conditions, and it has a contract with Correct Rx pharmacy to supply necessary medications and refills. Correct Rx has a 24-72 hour turnaround on ordered medications. Over the counter (OTC) medications are provided the medical staff and available for purchase at the commissary.

The MARs from the previous month have already been filed in the charts; the FMC did not find any unfiled MARs in the medical records filing area. An estimated 30% of detainees are currently on self-administered medications that have been ordered by a physician.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

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Continuity of Medication

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 710-Medication Administration, 615-B Intake Screening.

1. Ten of ten (100%) had medications ordered in less than 24 hours from intake screening.
2. Ten of ten (100%) had first dose of medication within 24 hours of order.

During the intake screening process, the nurses contact the provider to initiate chronic care (CC) medications.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Mental Health Screen

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed: 616-A Mental Health Screening, Evaluation and Services.

1. Ten of ten (100%) detainees that had a positive screen for mental illness were referred for evaluation and were seen within a timely manner.

Current processes in place indicated no mental health referral issues during this review.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Medical Recordkeeping Practices

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed: 301- Access to Storage and Confidentiality of Health Records.302-Charting in Health Records.

Medical records are located in a secured medical records room in filing cabinets. Medical record files are organized in specific sections within the chart that allows for easy navigation of the file. Medical records staff were noted to be very efficient in the retrieval of records and organization of the medical records area.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Pregnant Women

There have been zero pregnant women since the last site visit.

DCDC policy reviewed; 621-A Pregnancy Management.

Per GEO policy, all female detainees receive a urine pregnancy test during intake assessment. The intake assessment includes an additional page for females that include questions about number of pregnancies, last menstrual period, last sexual intercourse

Previous FMC site visit from 6/12/2016: Zero of two pregnant detainee had OB/GYN consult initiated.
Current site visit findings: No charts to review. GEO did change their policy to state that all pregnant females must be referred to OB/GYN.

**Since the site visit was conducted, the facility received one pregnant female, and an OB/GYN referral was placed the following day.

Dental Care

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Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 101-Dental Treatment Priorities, 102-Oral Care

1. Ten of ten (100%) were screened for symptoms during intake process.
2. Ten of ten (100%) were evaluated by a qualified health professional within 48 hours of request.
3. Ten of ten (100%) had dental clinical notes describing findings, diagnosis, treatment and plans.
4. Ten of ten (100%) had follow-up treatment as recommended.

A dentist and dental assistant provide routine dental services on Monday through Thursday each week at the facility. The dental room has two exam chairs, autoclave instruments and other dental supplies available. The room is kept locked at all times.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policy reviewed; 1003-A Diagnostic Services
1. Ten of ten (100%) had blood drawn or test done within one business day of ordered date.
2. Ten of ten (100%) had report back within 24 hours.
3. Ten of ten (100%) had clinical acknowledgment.
4. Ten of ten (100%) had appropriate clinical response.
5. Nine of nine (100%) patients were advised of lab results. One lab was just received by the facility the day prior to the chart review.

DCDC uses Labcorp for all laboratory services.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Diagnostic Services and Specialty Care Access

Nine charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 1003-Diagnostic Services, 211-Off site hospital and specialty care, 214-A referrals, outside medical care.

1. Nine of nine (100%) had a documented time urgency included in the order.
2. Seven of seven (100%) were completed within the time specified or 45 days, and the majority were completed within 14 days.
3. None required a re-evaluation for deterioration at least every 30 days until off-site service provided.
4. Seven of seven (100%) were reviewed by the clinician within seven days.

DCDC has a contract with Denver Health which has its own designated correctional health care unit. When specialty care is needed, the CD contacts the Denver Health care coordinator to schedule the appointment. DCDC has access to a full range of specialty services.
DCDC has a full time on-site x-ray technician.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Mental Health Treatment Planning

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 623-Psychiatric Evaluation

1. Ten of ten (100%) had a clinical assessment, treatment and follow-up plan documented.
2. Nine of nine (100%) had treatment plans which were updated at least every 90 days.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Treatment of Disability

One chart was reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 901-B Aids to Impairment (Special Needs and Services), 906-Special Needs Inmate/Detainee.

1. One of one (100%) had the disability noted in the file.
2. One of one (100%) was assessed for assistance with activities of daily living. ADL assistance was not needed for this detainee.
3. One of one (100%) had appropriate accommodation orders.

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DCDC has special needs equipment available, i.e. handicap cells, wheelchairs, canes, walkers. Detainees with vision and hearing disabilities have access to special services i.e. blind man cane. The facility maintains a list of detainees with disabilities.
The HSA provided ERO staff and FMC with a copy of the detainee disability accommodation notification form.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

Complaints and Grievances

Seventeen charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 205-Grievances

There was a total of 28 medical grievances in the past three months.
One for denial/refusal of specific request for care.
Sixteen for delays in care.
One for competency/professional mindset of medical staff.
Three for attitude, demeanor or conduct of staff.
Seven classified as other.
27 of 28 charts (96%) were addressed in writing by the HSA within five working days. There was evidence that the majority of complaints were due to delayed appointments.

Previous FMC site visit from 06/12/2017: There were three grievances not answered within the five day period stated in the standard.
Current site visit findings 1/22/18: Repeat deficiency. 27 of 28 grievances were answered within five days. One was answered on day 7.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Six charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 606-A Diabetes Mellitus Management

1. Five of five (100%) had blood sugar measured and recorded on intake. One refused.
2. One of six (17%) were seen for chronic care within fourteen days of illness identification.
3. Five of five (100%) had a baseline HgbA1c performed within 30 days of intake or within the past 3 months. One refused lab draw.
4. Five of five (100%) had lipids measured within one year. One refused lab draw.
5. Two of three (67%) were followed at least every 90 days with appropriate vital signs.
6. Three of three (100%) had aspirin prescribed as clinically indicated.
7. Five of five (100%) had degree of control documented.
8. Six of Six (100%) had a documented strategy to attain diabetes control.

The facility uses GEO and the Bureau of Prisons (BOP) clinical guidelines.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.

Human Immunodeficiency Virus (HIV)

One inactive chart was reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy review; 511-A HIV Prevention and Management

1. One of one (100%) was identified by patient interview.
2. One of one (100%) had CD4 and viral load completed within 14 days of arrival.
3. Detainee bonded out prior to chronic care appointment.
4. One of one (100%) had antiretroviral treatment documented.
5. The detainee bonded out prior to the 90 day chronic care appointment.
6. One of one (100%) had a chest x-ray completed within 72hours of problem identification.

The providers follow Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), GEO group clinical practice guidelines and the HIV Medicine Association of the Infectious Disease Society of America to manage HIV detainees.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: Best practice. A referral for an Infectious Disease provider or HIV specialist had not been made.

Hypertension

Ten charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Hypertension.

1. Ten of ten (100%) had blood pressure reading documented during intake.
2. Five of ten (50%) were evaluated by an MD/PA/NP within 14 days of illness identification. One was a new arrival, had appointment scheduled.
3. Three or three (100%) were noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.
4. Ten of ten (100%) were treated under a chronic disease guideline which included baseline laboratory testing.

Previous FMC site visit from 6/12/2017: No findings noted.

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Current site visit findings 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.

Asthma

Six charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Asthma.

1. One of six (17%) were seen in the chronic care clinic within 14 days of illness identification.
2. Six of six (100%) had documented peak flow measurements during the initial physical exam.
3. Four of four (100%) had documented peak flow measurements during the last chronic care visit or within the last 3 months.
4. Six of six (100%) were treated under a chronic disease guideline which addressed disease severity, prescription of medications consistent with severity and documented degree of control.

Previous FMC site visit from 6/12/2017: No findings noted.

Current site visit findings 1/22/2018: Physical exam/chronic care was not routinely done within 14 days.

Seizure Disorder

One charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Seizures.

1. One of one (100%) had an appropriate neurological history completed at the initial physical examination.
2. One of one (100%) was seen by a provider within 14 days of illness identification
3. One of one (100%) had serum drug levels performed and acknowledged in the medical record every three months until stable.
4. One of one (100%) had a treatment plan established.
5. one of one (100%) were given bottom bunk.

Previous FMC site visit from 06/12/2017: No findings noted.

Current site visit findings 1/22/2018: No findings noted.

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Recommendations

(b)(5)

Facility Actions

The HSA and GEO regional program manager were notified of all findings/recommendations during the close-out.
1) The facility was without a PA from July 2017-January 2018 due to an unexpected death.
(b)(7)(E)

(b)(5); (b)(7)(E)

Additional Comments

The GEO Group chronic care flow sheets do an excellent job of covering all of IHSC Quality of Care Audit tools for chronic diseases. They cover degree of control, treatment, labs, follow-up appointments, etc. for the specified chronic disease.
The facility was behind on physical exams, chronic care and provider sick call appointments at the time of the FMC site visit. The FMC did see evidence of progress being made towards the exams being caught up to date once the PA was hired in January.

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End of Report

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Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 02/01/2018
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Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 02/08/2018

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
06/12/2017	12/12/2016	Denver Contract Detention Center (DCDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
607	540	67	1	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739- (b)(6); (b)(7)(C)	Phone Number: +1 (303) 739- (b)(6); (b)(7)(C)
Address: 11901 East 30th Avenue Aurora, CO 80010	Address: 11901 East 30th Avenue Aurora, CO 80010

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

-Previous site visit findings 12/12/2016: No deficiencies noted.

-Current site visit findings 6/12/2017:
PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: Three grievances were not answered within 5 working days.

GEO Corporate conducted an annual audit and review June 5-9, 2017.

The Nakamoto Group conducted an annual inspection on September 27-29, 2016. All standards were met, and no deficiencies were noted.

The Commission on Accreditation for Corrections (ACA) conducted a review on November 14-16, 2016. All ACA standards were met, and no deficiencies were noted.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
57	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
DCDC policy reviewed; 605-A Continuity of Care, 603-A Access to Care, 607-Therapeutic Diets

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Previous site visit findings 12/12/2016: No deficiencies noted.

Current site visit findings 6/12/2017: No deficiencies noted.

The medical clinic has a designated chronic care registered nurse (RN) who oversees scheduling of chronic care clinic appointments, off site referrals, updating physician orders and working along side the physician. All chronic care patients were noted to be identified and screened appropriately during intake. All were referred to the providers, and initial chronic care visits were completed within fourteen days. Chronic care guidelines are based on the Bureau Of Prisons guidelines.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 614-A Hunger Strike

Previous FMC site visit from 12/12/2016: No deficiencies noted.

Current site visit findings 6/12/2017: No deficiencies noted.

Review of the facility's hunger strike policy noted to follow NCCHC and PBNDS standards. A review of the medical record showed appropriate care and documentation.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	5

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 907-C Suicide prevention and intervention.

Previous FMC site visit from 12/12/2016: No deficiencies noted.

Current site visit findings 6/12/2017: PBNDS 2011 Medical Care 4.6.D Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record.
CURRENT FINDINGS: Review of medical records revealed evaluation and assessments were not documented on a daily basis.

There have been five suicide watches since the last audit. Documentation of continuous patient observation and/or every 15 minute observation was noted in the medical charts. Nursing assessments were not documented on a daily basis. Nursing would initial the monitoring flow sheet that rounds were done, but documentation of assessments were inconsistent.
Mental health evaluations were not documented consistently on a daily basis in two medical records.
The corporate audit preformed by GEO on June 5-9, 2017 revealed the same deficiency. The HSA completed a corrective action plan for this deficiency that includes a change of policy stating nursing assessments will be performed and documented every eight hours.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of a Inmate/Detainee/Resident, 210-Notification in Emergency or Death.

Previous FMC site visit from 12/12/2016: No deficiencies noted.

Current site visit findings 6/12/2017: No deficiencies noted.

There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months. The local policies are in compliance with the PBNDS 2011 standard.

Other Observations

The FMC conducted this site visit on June 12-14, 2017. A total of approximately 57 charts were reviewed for this audit. DCDC uses paper medical records.

Facility Data:
DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 1,100 detainees. The current ICE contract allows 928 ICE detainees. The facility has 78 U.S. Marshall detainees at the present time. On October 1, 2016, the ICE contract was increased from 525 beds to 928 beds; however, according to the Assistant Field Office Director (AFOD) assigned to DCDC, the number of beds may decrease due to a smaller population.
An adjacent building was renovated in preparation for another increase of bed space in February 2017; however, that bed space is not needed at this time. Medical equipment had already been purchased and received in preparation for the expansion. Medical staffing had also already been approved by GEO prior to the contract being obtained.

DCDC current medical staff includes:

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(b)(7)(E)

The medical clinic has eight medical housing unit rooms, five negative pressure rooms, and one suicide observation room.

There is a designated trauma/urgent care room which contains a urgent response cart, three AEDs, two gurneys, an eye wash shower, and other emergency supplies.

DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines. The HSA stated that the state of Colorado has the Corporate Practice of Medicine Law which says the physician's clinical judgment is to be followed. Meaning the physician may deviate from the guidelines if, in their clinical judgment, it is best for the patient.

DCDC Emergency Medical Services and First Aid policies reviewed; 1004-Emergency Medications and First Aid Kits, 608-A Emergency Services. Correctional staff receives appropriate training. DCDC policy reviewed; 409-A Training, Correctional officers.

Staff Training:
DCDC HSA conducts monthly staff meeting and training. Meeting minutes were reviewed. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. GEO policy only mandates that the medical staff conducts emergency response training annually. The HSA reported quarterly man down drills for every shift. Recent man down drill with after actions report was provided to FMC for review.

DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation was noted in non-English speaking charts.

(b)(7)(E) staff personnel files reviewed. All licensed personnel files had current up to date licenses to practice in the state of Colorado. All had up to date BLS certification.

Deficiencies for Areas Evaluated

-Previous site visit findings 12/12/2016: No deficiencies noted.

-Current site visit findings 6/12/2017:
PBNDS 2011 Medical Care 4.6.D Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record.
CURRENT FINDINGS: Review of medical records revealed evaluation and assessments were not documented on a daily basis.

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Current site visit findings 06/12/2017:
PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
CURRENT FINDINGS: Three grievances were not answered within 5 working days.

Quality of Care findings:
- Suicide watch nursing assessments were not documented on a daily basis. Nursing would initial the monitoring flow sheet that rounds were done, but documentation of assessments were inconsistent.

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Suicide Screening

Five charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.
DCDC policy reviewed; 907-C Suicide prevention and intervention. 616-B Mental Health Screening, Evaluation and Services.

1. Five of five (100%) suicidal patients were evaluated by a mental health professional within 24 hours.
2. Three of five (60%) evaluated daily by a qualified mental health professional. Two did not have daily documentation.
3&4. Five of five (100%) were on continuous watch monitoring and/or every 15 minute watch with checks documented.
5. Zero of five (0%) had evidence that earlier intervention would have prevented the suicide watches.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 05/12/2017: PBNDS 2011 Medical Care 4.6.D Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis, with this re-evaluation documented in the detainee's medical record.
CURRENT FINDINGS: Review of medical records revealed evaluation and assessments were not documented on a daily basis.

There have been five suicide watches since the last audit. Documentation of continuous patient observation and/or every 15 minute observation was noted in the medical charts. Nursing assessments were not documented on a daily basis. Nursing would initial the monitoring flow sheet that rounds were done, but documentation of assessments were inconsistent.
Mental health evaluations were not documented consistently on a daily basis in two medical records.
The corporate audit preformed by GEO on June 5-9, 2017 revealed the same deficiency. The HSA completed a Corrective Action Plan for this deficiency that includes a change of policy stating nursing assessments will be performed and documented every eight hours.

Health Assessment

20 detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policies reviewed; 601-A Physicals and Health Assessments, 615-B Intake Screening.

1. 20 of 20 (100%) had initial screenings that were completed within 12 hours of arrival.
2. 20 of 20 (100%) received tuberculosis (TB) screening in accordance with requirements. .
3. One of one (100%) were referred for evaluation who screened positive for mental illness or suicide risk.
4. 20 of 20 (100%) had timely follow up of a chronic condition and had a completed health evaluation within 14 days.
5. 20 of 20 (100%) received a complete health evaluation in accordance with requirements.

RNs are trained and signed off by the CD to conduct physical exams. All detainees noted to have chronic care diagnosis will be referred to the mid level provider or CD for further evaluation.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

Urgent Care (Sick Call)

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 625-Sick Call and Triaging of Non-Emergent Request for Health Services; GEO Request for Health Services Form HS-154.

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1. Ten of ten (100%) had timely and appropriate evaluation by nursing staff.
2. Ten of ten (100%) received care within the scope of the nurse's license.
3. Ten of ten (100%) had vital signs documented during the nurse's assessment.
4. Six of six (100%) patients were appropriately referred within 24 hours of initial sick call assessment to an MD/PA/NP/DMD.
5. Six of six (100%) patients referred had an MD/PA/NP/DMD assessment and plan documented.

Sick call slips can be turned in through a secure lock box in each pod or passed directly to the pill line nurse. Sick call request slips are picked up daily, reviewed and triaged by the nurse the same day. All urgent requests were noted to be seen the same day and all others within 48 hours.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Three detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policies reviewed; 608-B Emergency Services Patient Transport, 613-A Hospitalizations.

1. Three of three (100%) had an outbound progress note.
2. Three of three (100%) did not have evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care.
3. Three of three (100%) had discharge documentation from the hospital or ED in the chart.
4. Three of three (100%) had an inbound assessment documented.
5. Three of three (100%) had an inbound assessment reflecting hospital findings and concurrence or deviation from hospital recommendations.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

Medication Administration Practices

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area. 40 Medication Administration Record (MAR) were reviewed from the June MAR binder.

DCDC policies reviewed; 710-Medication Administration, 405-A Medication Administration Training.

FMC did not find any MARs with three consecutive missed or refused doses. The facility currently uses paper MARs which showed no missed doses except for refusals which were documented on the back of the MARs.

Per GEO policy and IHSC tool kit, an appropriate response from the prescribing clinician should be documented after three consecutive refusals.

The medical department has a wide variety of medications in stock to treat acute and chronic conditions, and it has a contract with Correct Rx pharmacy to supply necessary medications and refills. Correct Rx has a 24-72 hour turnaround on ordered medications. Over the counter (OTC) medications are provided the medical staff and available for purchase at the commissary.

The MARs from the previous month have already been filed in the charts; the FMC did not find any unfiled MARs in the medical records filing area. An estimated 30% of detainees are currently on self-administered medications that have been ordered by a physician.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

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Continuity of Medication

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 710-Medication Administration, 615-B Intake Screening.

1. Ten of ten (100%) had medications ordered in less than 24 hours from intake screening.
2. Ten of ten (100%) had first dose of medication within 24 hours of order.

During the intake screening process, the nurses contact the provider to initiate chronic care (CC) medications. A review of 20 charts of detainees with various chronic conditions indicated that routine medications were initiated within 48 hours.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Mental Health Screen

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed: 616-A Mental Health Screening, Evaluation and Services.

1. Ten of ten (100%) detainees that had a positive screen for mental illness were referred for evaluation and were seen within a timely manner.

Current processes in place indicated no mental health referral issues during this review.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

Medical Recordkeeping Practices

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed: 301- Access to Storage and Confidentiality of Health Records.302-Charting in Health Records.

Medical records are located in a secured medical records room in filing cabinets. Medical record files are organized in specific sections within the chart that allows for easy navigation of the file. Medical records staff were noted to be very efficient in the retrieval of records and organization of the medical records area.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 6/12/2017: No findings noted.

Pregnant Women

Two detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 621-A Pregnancy Management.

1. Two of two (100%) had pregnancy test performed during intake screening.
2. Two of two (100%) demonstrated proper care of pregnancy test prior to x-ray or before initiation of medications.
3. Zero of two (0%) had an OB doctor consult ordered within 7 days of confirmation. Records were obtained from the OB provider of the detainee who stayed longer than seven days.
4. Zero of one (0%) were seen by OB within 30 days of confirmation. One detainee left the facility after 7 days.
5. Two of two (100%) had screening for HIV, STI, and hepatitis.
6. One of one (100%) had prenatal vitamins prescribed. Health assessments included female specific items as per standards.

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The CD completed a full pregnancy work up and evaluation during the chronic care clinic visit. Required laboratory tests were ordered and obtained, including HIV, STI and viral hepatitis. The detainee is seen monthly at the chronic care clinic for routine follow up appointments.

Per GEO policy, all female detainees receive a urine pregnancy test during intake assessment. Pregnant detainees are to be seen at least monthly by an obstetrician or facility providers per GEO policy. The clinical director reports experience in obstetrics.

Previous FMC site visit from 12/12/2016: Zero of one pregnant detainees had OB/GYN consults initiated.

Current site visit findings 6/12/2017: Zero of two pregnant detainee had OB/GYN consult initiated. The clinical director obtained records from the provider the detainee was seeing prior to being detained.

Dental Care

Ten charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 101-Dental Treatment Priorities, 102-Oral Care

1. Ten of ten (100%) were screened for symptoms during intake process.
2. Ten of ten (100%) were evaluated by a qualified health professional within 48 hours of request.
3. Ten of ten (100%) had dental clinical notes describing findings, diagnosis, treatment and plans.
4. Six of six (100%) had follow-up treatment as recommended.

A dentist and dental assistant provide routine dental services on Monday through Friday of each week at the facility. The dental room has two exam chairs, autoclave instruments and other dental supplies available. The room is kept locked at all times.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

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Acute Laboratory Testing

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policy reviewed; 1003-A Diagnostic Services
1. Ten of ten (100%) had blood drawn or test done within one business day of ordered date.
2. Ten of ten (100%) had report back within 24 hours.
3. Ten of ten (100%) had clinical acknowledgment.
4. Ten of ten (100%) had appropriate clinical response.
5. Nine of nine (100%) patients were advised of lab results. One left prior to results being returned.

DCDC uses Labcorp for all laboratory services.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Diagnostic Services and Specialty Care Access

Seven charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 1003-Diagnostic Services, 211-Off site hospital and specialty care, 214-A referrals, outside medical care.

1. Seven of seven (100%) had a documented time urgency included in the order. The other four orders written were for radiology which is done in house. All 4 were done same day.
2. Seven of seven (100%) were completed within the time specified or 45 days, and the majority were completed within 14 days.
3. One of one (100%) were re-evaluated for deterioration at least every 30 days until off-site service provided. The other six were completed before 30 days.
4. Seven of seven (100%) were reviewed by the clinician within seven days.

DCDC has a contract with Denver Health which has its own designated correctional health care unit. When specialty care is needed, the CD contacts the Denver Health care coordinator to schedule the appointment. DCDC has access to a full range of specialty services.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Mental Health Treatment Planning

Ten detainee charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 623-Psychiatric Evaluation

1. Ten of ten (100%) had a clinical assessment, treatment and follow-up plan documented.
2. Four of four (100%) had treatment plans which were updated at least every 90 days. The other five patients were transferred prior to the 90 day follow-up.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Treatment of Disability

Three chart was reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

DCDC policies reviewed; 901-B Aids to Impairment (Special Needs and Services), 906-Special Needs Inmate/Detainee.

1. Three of three (100%) had the disability noted in the file.
2. Three of three (100%) was assessed for assistance with activities of daily living.
3. Three of three (100%) had appropriate accommodation orders.

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4. NA

DCDC has special needs equipment available, i.e. handicap cells, wheelchairs, canes, walkers. Detainees with vision and hearing disabilities have access to special services i.e. blind man cane. The facility maintains a list of detainees with disabilities.
The HSA provided ERO staff and FMC with a copy of the detainee disability accommodation notification form. The form was found at the front of all three charts.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Complaints and Grievances

Seventeen charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 205-Grievances

There was a total of seventeen medical grievances in the past three months.
Five for availability of care.
Eight for denial/refusal of specific request for care.
Zero for delays in care.
Two for competency/professional mindset of medical staff.
One for attitude, demeanor or conduct of staff.
One classified as other.
14 of 17 charts (82%) were addressed in writing by the HSA within five working days. The other three were answered within a timely manner. There was no evidence of any possible barriers to care or repetitive concerns that could affect clinical care.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
There were three grievances not answered within the five day period stated in the standard.
The HSA is currently the only staff member that responds to complaints and grievances.

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Diabetes

Five charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; 606-A Diabetes Mellitus Management

1. Five of five (100%) had blood sugar measured and recorded on intake.
2. Five of five (100%) were seen for chronic care within 14 days of illness identification.
3. Five of five (100%) had a baseline HgbA1c performed within 30 days of intake or within the past 3 months.
4. Five of five (100%) had lipids measured within one year.
5. Two of two (100%) were followed at least every 90 days with appropriate vital signs.
6. Three of three (100%) had aspirin prescribed as clinically indicated.
7. Five of five (100%) had degree of control documented.
8. Five of five (100%) had a documented strategy to attain diabetes control.

The facility uses GEO and the Bureau of Prisons (BOP) clinical guidelines.

Previous FMC site visit from 12/12/2016: One medical record did not have a blood sugar recorded on intake.

Current site visit findings 6/12/2017: No findings noted.

Human Immunodeficiency Virus (HIV)

One chart was reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy review; 511-A HIV Prevention and Management

1. One of one (100%) was identified by patient interview.
2. One of one (100%) had CD4 and viral load completed within 14 days of arrival.
3. One of one (100%) was seen by a HIV or ID specialist within 30 days of arrival. **
4. One of one (100%) had antiretroviral treatment documented.
5. The detainee was released prior to the 90 day chronic care appointment.
6. 1 of 1 (100%) had a chest x-ray completed within 72hours of problem identification.

** The detainee was being followed by an ID specialist at Denver Health prior to arriving at the facility. Consult notes from the specialist were obtained and reviewed by the clinical director.

The providers follow Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), GEO group clinical practice guidelines and the HIV Medicine Association of the Infectious Disease Society of America to manage HIV detainees.

The Chronic Care nurse organized a training through the Colorado Department of Health and Environment which allows for pre and post HIV test counseling to be done by the RN. Four RNs and the CD have completed the training. However, if the test is positive, it has to be done by the physician.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Hypertension

Ten charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Hypertension.

1. Ten of ten (100%) had blood pressure reading documented during intake.
2. Nine of nine (100%) were evaluated by an MD/PA/NP within 14 days of illness

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identification. One was a new arrival and had an appointment scheduled.
3. Eight of eight (100%) were noted to have blood pressures above 140/90 with a treatment plan initiated within 14 days of identification.
4. Ten of ten (100%) were treated under a chronic disease guideline which included baseline laboratory testing.

Hypertension blood pressure flow sheets and chronic care documents were noted in ten of ten charts.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Asthma

Four charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Asthma.
1. Four of four (100%) were seen in the chronic care clinic within 14 days of illness identification.
2. Four of four (100%) had documented peak flow measurements during the initial physical exam.
3. Four of four (100%) had documented peak flow measurements during the last chronic care visit or within the last 3 months.
4. Four of four (100%) were treated under a chronic disease guideline which addressed disease severity, prescription of medications consistent with severity and documented degree of control.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

Seizure Disorder

Zero charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area. DCDC has not had any seizure patients since the last site visit.

DCDC policy reviewed; Geo Group- Clinical Practice Guidelines (adopted from Fed BOP Guidelines), Chronic Care form-Seizures.

Guidelines and chronic care form outlines an appropriate plan of care including labs, lower bunk and treatment plan.

Previous FMC site visit from 12/12/2016: No findings noted.

Current site visit findings 06/12/2017: No findings noted.

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Recommendations

(b)(5)

Facility Actions

1) Suicide watch documentation; the HSA stated a corrective action plan has already been completed after the corporate audit and will be implemented immediately.

Additional Comments

The GEO Group chronic care flow sheets do an excellent job of covering all of IHSC Quality of Care Audit tools for chronic diseases. They cover degree of control, treatment, labs, follow-up appointments, etc. for the specified chronic disease.

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End of Report

IHSC, Field Medical Coordinator	
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Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 07/13/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/18/2017

Recommendations:

(b)(5)

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Reset Form | Email Form | Print Form

DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
03/25/2019	11/13/2018	Denver Contract Detention Center (DCDC)

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,252	1,077	175	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
6	6	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)	Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)
Address: 3130 Oakland St. Aurora, CO 80010	Address: 3130 Oakland St. Aurora, CO 80010

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Site visit findings 3/25/2019.
19 of 23 (83%) grievances were answered within 5 working days.
- PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
Repeat finding.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
76	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 605-A Continuity of Care, 603-A Access to Care, 607-Therapuetic Diets

Site visit findings 3/25/2019
16 of 18 (89%) Detainee with a chronic condition were seen by a provider within two working days.
- PBNDS 2011 4.3.J, Where there is a significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.
- NCCHC Standard; J-E-04, Initial Health Assessment. Inmates identified with clinically significant findings as the result f a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.

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GEO group chronic care guidelines are based on the Bureau Of Prisons guidelines.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 614-A Hunger Strike

Previous site visit findings 11/13/2018: No deficiencies noted.

Current site visit findings 3/25/2019: No deficiencies noted.

Review of the facility's hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	11

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policy reviewed; 907-C Suicide prevention and intervention.

Previous site visit findings 11/13/2018: No deficiencies noted.

Current site visit findings 3/25/2019: No deficiencies noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of a Inmate/Detainee/Resident, 210-Notification in Emergency or Death.

Previous site visit findings 11/13/2018: No deficiencies noted.

Current site visit findings 3/25/2019: No deficiencies noted.

There have no detainee deaths since the previous site visit.

Other Observations

The FMC conducted this site visit on March 25-28, 2019. A total of 62 charts and 65 Medication Administration Records (MARs) were reviewed for this audit.
- The FMC focused on detainee charts that arrived after the last site visit to present.

--FACILITY DATA:
- DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 976 detainees.
- An adjacent annex was opened on January 21, 2019 on a 90 day contract for an additional 432 beds. Discussions and contract proposals are all pending for possible continuation of use for the annex building.

--ACCREDITATIONS/INSPECTIONS:
- ACA - November 2016.
- PBNDS (Nakamoto Group)- September 2017.
- Office of Detention Oversight (ODO) - January 2018.
- IHSC Investigative Unit, Mortality review. - January 2018.
- PREA Audit - April 2018, DOJ
- GEO Corporate Audit - June 2018
- Civil Right and Civil Liberties - August 2018
- PREA Audit - October 2018, DHS
- NCCHC - October 2018
- Nakamoto - November 2018
- OIG - November 2018

--MEDICAL STAFFING:
See QMC toolkit.

(b)(7)(E)

--STAFFING VACANCIES:

(b)(7)(E)

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(b)(7)(E)

--MEDICAL CLINIC

(b)(7)(E)

--STAFF TRAINING:
- DCDC HSA conducts monthly staff meeting and training. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. Training topics were reviewed and align with accreditation standards.

--SUPPLEMENTAL INFO:
- DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation were noted in non-English speaking charts.
- DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines.

Deficiencies for Areas Evaluated

Site visit findings 11/13/2018. 19 of 23 (83%) grievances were answered within 5 working days.
- PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable.
Repeat finding.

Site visit findings 3/25/2019
16 of 18 (89%) Detainees with a chronic condition were seen by a provider within two working days.
- PBNDS 2011 4.3.J, Where there is a significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.
- NCCHC Standard; J-E-04, Initial Health Assessment. Inmates identified with clinically significant findings as the result f a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Health Assessment

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: 16 of 18 (89%) Detainees with a chronic condition were seen by a provider within two working days

Urgent Care (Sick Call)

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Medication Administration Practices

See QMC toolkit.

Previous site visit findings 11/13/2018: The FMC found <5% of the MARs to have blanks. MARs were waiting to be filed into the charts.

Current site visit findings 3/25/2019: No new findings noted. Since the last site visit, MARs have been filed in the charts on a timely basis. However, there are still 3-4 months of MARs from last year waiting to be filed.

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Continuity of Medication

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Mental Health Screen

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: Eight of ten (80%) detainees were seen by mental health within 14 days of arrival.

Medical Recordkeeping Practices

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Pregnant Women

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Dental Care

See QMC toolkit.

Previous site visit findings 4/24/2018: No findings noted.

Current site visit findings 11/13/2018: 9 of 10 (90%) detainees were evaluated within 48 hours of request.

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Acute Laboratory Testing

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Diagnostic Services and Specialty Care Access

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: Two appointments were not accomplished within 45 days of the order; however, neither are considered findings. The first was delayed due to the government shutdown and the second was a surgery request that is still pending.

Mental Health Treatment Planning

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Treatment of Disability

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Complaints and Grievances

See QMC toolkit.

Previous site visit findings 11/13/2018: 24 of 27 grievances were answered within five working days.
Current site visit findings 3/25/2019: 19 of 23 grievances were answered within five working days. Repeat finding.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Human Immunodeficiency Virus (HIV)

See QMC toolkit.

Previous site visit findings 11/13/2018: One detainee was not seen by an ID specialist within 30 days.

Current site visit findings 3/25/2019: Two detainees were not seen by an ID specialist within 30 days. Both were established HIV patients, 10+yrs of HIV on medications.

Hypertension

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Asthma

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

Seizure Disorder

See QMC toolkit.

Previous site visit findings 11/13/2018: No findings noted.

Current site visit findings 3/25/2019: No findings noted.

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Recommendations

(b)(5)

Facility Actions

1) Health assessments. The FMC noted that there was an 400+ increase in beds without a permanent contract and increase of permanent staff

Additional Comments

(b)(7)(E)

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (720) 873- (b)(6); (b)(7)(C)	Date Prepared: 04/04/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 04/05/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 04/05/2019

Recommendations:

(b)(5)

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Denver Contract Detention Center (Aurora ICE Processing Center)			
AOR:*	DEN			
Address:	3130 Oakland St			
City:	Aurora		**County:**	Adams
State:*	CO	**Zip:**	80010	
Inspection Information				
Start Date:*	11/13/2018			
End Date:*	11/16/2018			
Organization:*		Other		
# Detainees at Time of Visit:		882		
Total Facility Population at Time of Visit:				
Facility Capacity:		1100		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	12/12/2018
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by: People			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	86%	
CG	Complaints and Grievance	27	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	100%	
DM	Diabetes	100%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	80%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	90%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records		
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women	90%	
SZ	Seizure Disorder	100%	
SS	Suicide Screening	75%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1 AHSA						
Other 2 QA nurse						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene,

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.
- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in
- In most cases, the recommended sample size will provide a reliable picture of care that can be
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq 90\%$. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide

TIPS FOR REVIEWERS

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• Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.
• Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.
• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		7						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	#1 - peak flow not done at PE on 6/5, but was done at CCC on 6/14. #4,5,6 - peak flow done at initial CCC at day #30.							
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	11/15/2018			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?	Management of Asthma , adapted from BOP						
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		7	7	7	7			
Total Met:		7	3	7	7			
% Compliance:	86%	100%	43%	100%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	No	Yes	Yes			
2		Yes	Yes	Yes	Yes			
3		Yes	Yes	Yes	Yes			
4		Yes	No	Yes	Yes			
5		Yes	No	Yes	Yes			
6		Yes	No	Yes	Yes			
7		Yes	Yes	Yes	Yes			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	#1 - detainee was sent to ER during intake for chest pain, blood sugar was measured at hospital. #5 - labs just returned, has not been seen for CCC yet. #6 - refused lab draw x2, refusal forms signed.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 11/14/2018

Facility (f)

fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	GEO policy #606, 606-A. CPG- Management of Diabetes protocol. Adapted from BOP

Clinical (c)

cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		9	10	9	9	3	4	8	3
Total Met:		9	10	9	9	3	4	8	3
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	N/A	Yes	Yes	Yes	Yes	Yes	Yes	N/A - NLOS
2		Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
5		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS
6		Yes	Yes	N/A - NLOS	N/A - NLOS	N/A - LOS	N/A - NLOS	N/A - NLOS	N/A - NLOS

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
7	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	
8		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - NLOS	
9		Yes	Yes	Yes	Yes	N/A - LOS	Yes	Yes	N/A - NLOS	
10		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	N/A - NLOS	

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HIV								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu					
	University of California, San Francisco. HIV Clinical Consultation Center.							
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
Remarks:	#1- referral ordered, left prior to appt GEO policy # 511, 511-A							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	11/13/2018				
Facility (f)								
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	Management of HIV Infection.						
Clinical (c)								
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?							
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
cHIV-4	Was antiretroviral treatment considered and documented?							
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
Total Applicable:			3	2	3	2	3	
Total Met:			3	1	3	2	3	
% Compliance:	90%		100%	50%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	N/A - LOS	Yes	N/A - LOS	Yes	

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
2	(b)(6); (b)(7)(C)	Patient Interview	Yes	No	Yes	Yes	Yes	
3		Patient Interview	Yes	Yes	Yes	Yes	Yes	
4		Select	Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

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HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		Management of Hypertension, Adapted from BOP protocol			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	9	10	
Total Met:		10	10	9	10	
% Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**	
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	Yes	
2		y	Yes	Yes	Yes	
3		y	Yes	Yes	Yes	
4		Y	Yes	Yes	Yes	
5		Y	Yes	Yes	Yes	
6		Y	Yes	Yes	Yes	
7		Y	Yes	Yes	Yes	
8		Y	Yes	Yes	Yes	
9		Y	Yes	Yes	Yes	
10		Y	Yes	Yes	Yes	

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		2				
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	#2 - did not report upon intake. Was seen by PA after reported.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	GEO Group - Clinical Practice Guidelines				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		2	2	1	2	2
Total Met:		2	2	1	2	2
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	N/A - NLOS	Yes	Yes
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess timeliness of medication, as ordered.								
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).								
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.								
Guidelines:									
Remarks:	DCDC policies reviewed; 710-Medication Administration, 615-B Intake Screening.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018				
Clinical (c)									
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?								
cCM-2	Period of time from order to first dose less than 24 hours?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cCM-1**	**cCM-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	DCDC policies reviewed; 101-Dental Treatment Priorities, 102-Oral Care							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/15/2018			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	10	8			
Total Met:		10	10	10	8			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	Yes	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	N/A - NLOS			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	N/A - NLOS			

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	8						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:	DCDC policies reviewed; 1003-Diagnostic Services, 211-Off site hospital and specialty care, 214-A referrals, outside medical care.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/15/2018		
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			8	8	1	8	
Total Met:			8	8	1	8	
% Compliance:	100%		100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1	(b)(6); (b)(7)(C)	Other	Yes	Yes	N/A - NLOS	Yes	
2		Other	Yes	Yes	N/A - NLOS	Yes	
3		Other	Yes	Yes	N/A - NLOS	Yes	
4		Other	Yes	Yes	N/A - NLOS	Yes	
5		Other	Yes	Yes	Yes	Yes	
6		Other	Yes	Yes	N/A - NLOS	Yes	
7		OB/Gyn	Yes	Yes	N/A - NLOS	Yes	
8		Infectious Disease	Yes	Yes	N/A - NLOS	Yes	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.						
Source:	Emergency Department (ED) logs.						
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.						
Guidelines:	NCCHC 2014 J-E-12.						
Remarks:	DCDC policies reviewed; 608-B Emergency Services Patient Transport, 613-A Hospitalizations.						
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	11/14/2018	
			Clinical (c)				
cEED-1	Is there an outbound progress note?						
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.						
cEED-3	Is there discharge documentation from the hospital or ED in the chart?						
cEED-4	Is there an inbound assessment?						
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?						
Total Applicable:			10	10	10	10	10
Total Met:			10	0	10	10	10
% Compliance:	80%		100%	0%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
1	(b)(6); (b)(7)(C)	chest pain	Yes	No	Yes	Yes	Yes
2		Jaw infection	Yes	No	Yes	Yes	Yes
3		abdominal pain	Yes	No	Yes	Yes	Yes
4		bloody stool, R/O GI bleed	Yes	No	Yes	Yes	Yes
5		chest pain	Yes	No	Yes	Yes	Yes
6		infected wound	Yes	No	Yes	Yes	Yes
7		abcess on leg	Yes	No	Yes	Yes	Yes
8		abdominal pain	Yes	No	Yes	Yes	Yes
9		ETOH withdrawal	Yes	No	Yes	Yes	Yes
10		cellulitis- rt knee	Yes	No	Yes	Yes	Yes

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	27						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	GEO policy #205, 205-A						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/16/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			27			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			23			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	27	7	8	6	1	1	5
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
1	(b)(6); (b)(7)(C)	1	Select	Select	Select	Select	Select

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
2	(b)(6); (b)(7)(C)	Select	1	Select	Select	Select	Select
3		Select	Select	Select	Select	Select	1
4		Select	Select	Select	Select	1	Select
5		Select	1	Select	Select	Select	Select
6		Select	1	Select	Select	Select	Select
7		Select	Select	1	Select	Select	Select
8		Select	Select	2	Select	Select	Select
9		1	Select	Select	Select	Select	Select
10		Select	1	Select	Select	Select	Select
11		Select	Select	1	Select	Select	Select
12		Select	1	Select	Select	Select	Select
13		Select	Select	Select	Select	Select	1
14		Select	Select	Select	Select	Select	1
15		Select	Select	1	Select	Select	Select
16		Select	Select	1	Select	Select	Select
17		1	Select	Select	Select	Select	Select
18		Select	1	Select	Select	Select	Select
19		Select	1	Select	Select	Select	Select
20		1	Select	Select	Select	Select	Select
21		1	Select	Select	Select	Select	Select
22		Select	Select	Select	Select	Select	1
23		Select	1	Select	Select	Select	Select
24		Select	Select	Select	Select	Select	1
25		1	Select	Select	Select	Select	Select
26		1	Select	Select	Select	Select	Select
27		Select	Select	Select	1	Select	Select

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HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	#14 - initial PE by MD delayed due to ETOH withrawal, sent to hospital but returned. Completed on first day possible, day #5.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	8	10	20
Total Met:		20	20	8	10	20
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	N/A - NLOS	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A	N/A - NLOS	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	N/A	N/A - NLOS	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	N/A	N/A - NLOS	Yes
9		Yes	Yes	N/A	N/A - NLOS	Yes
10		Yes	Yes	N/A	Yes	Yes
11		Yes	Yes	Yes	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	N/A	N/A - NLOS	Yes
16		Yes	Yes	N/A	N/A - NLOS	Yes
17		Yes	Yes	N/A	N/A - NLOS	Yes
18		Yes	Yes	N/A	N/A - NLOS	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	N/A	N/A - NLOS	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	DCDC policy reviewed; 1003-A Diagnostic Services. DCDC uses Labcorp for all laboratory services.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		10	10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS				
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	105			
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.			
Source:	MARS.			
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.			
Guidelines:				
Remarks:	DCDC policies reviewed; 710-Medication Administration, 405-A Medication Administration Training. No MAR's were found to have 3 or more missed doses or refusals.			
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	11/15/2018

Facility (f)		
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?	Y
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?	5
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?	3
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.	50
fMAR-5:	OTCs provided by medical, commissary or both?	Both

Clinical (c)	
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

Total Applicable:			0	0
Total Met:			0	0
% Compliance:				

Patient(s)	A# (numbers only)	cMAR-1	cMAR-2	cMAR-3
1	(b)(6); (b)(7)(C)	0	N/A - NLOS	N/A - NLOS
2		0	N/A - NLOS	N/A - NLOS
3		0	N/A - NLOS	N/A - NLOS
4		0	N/A - NLOS	N/A - NLOS
5		0	N/A - NLOS	N/A - NLOS
6		0	N/A - NLOS	N/A - NLOS
7		0	N/A - NLOS	N/A - NLOS
8		0	N/A - NLOS	N/A - NLOS
9		0	N/A - NLOS	N/A - NLOS
10		0	N/A - NLOS	N/A - NLOS

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MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # if no files/patients reviewed): 10

Purpose: To assess completeness of the medical record and appropriateness of medical record practices.
Source: Medical Records, Chronic Care Log, and MARs.
Sample: 10 records of detainees with chronic disease, if available.
Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines: NCCHC 2014 J-H-01, J-H-03.

(b)(6); (b)(7)(C)

Remarks: DCDC policies reviewed: 301- Access to Storage and Confidentiality of Health Records.302-Charting in Health Records.

Reviewer: **Date Reviewed:** 11/14/2018

Facility (f)

fMR-1: Type of Medical Records? Paper
fMR-2: Name of Electronic Health Record? N/A

Total Applicable:		10	10	10	10	10	7	10	10	10	7	0	1	0	0	10	10	10	0	10	0	0
Total Met:		10	10	10	10	10	7	10	10	10	7	0	1	0	0	10	10	10	0	10	0	0
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%			100%	100%	100%		100%		
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments; known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

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MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	GEO policy #616, 616-A								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**		11/14/2018			
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

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MENTAL HEALTH TREATMENT PLANNING								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).							
Source:	Patients on mental health caseload, including all patients on psychotropic medication.							
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.							
Guidelines:	NCCHC 2014 J-G-04 (Item 2)							
Remarks:	DCDC policy reviewed; 623-Psychiatric Evaluation							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/14/2018			
Clinical (c)								
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?							
cMHT-2	Are treatment plans updated at a minimum of every 90 days?							
Total Applicable:		10	6					
Total Met:		10	6					
% Compliance:	100%	100%	100%					
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**					
1	(b)(6); (b)(7)(C)	Yes	N/A - LOS					
2		Yes	Yes					
3		Yes	Yes					
4		Yes	Yes					
5		Yes	N/A - LOS					
6		Yes	N/A - LOS					
7		Yes	Yes					
8		Yes	Yes					
9		Yes	N/A - LOS					
10		Yes	Yes					

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		2					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	Lower bunk ordrered. #1-TAR was entered, but not seen within 30 days, OB's office rescheduled the appt to the following month - 60 days after arrival. GEO policy #621, 621-A						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**		11/15/2018	
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Yes			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		2	2	2	2	2	
Total Met:		2	2	1	2	2	
% Compliance:	90%	100%	100%	50%	100%	100%	
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	No	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	Type Text Here					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	11/13/2018		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		14			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Total Applicable:			10	10	10	10
Total Met:			10	10	10	0
% Compliance:	75%		100%	100%	100%	0%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		Constant (1:1)	Yes	Yes	Yes	No
10		Constant (1:1)	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		4					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	DCDC policies reviewed; 901-B Aids to Impairment (Special Needs and Services), 906-Special Needs Inmate/Detainee.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	11/15/2018		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		4	4	4	1		
Total Met:		4	4	4	1		
% Compliance:	100%	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS		
2		Yes	Yes	Yes	N/A - NLOS		
3		Yes	Yes	Yes	Yes		
4		Yes	Yes	Yes	N/A - NLOS		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

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URGENT CARE (SICK CALL)							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.						
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
Remarks:	DCDC policy reviewed; 625-Sick Call and Triaging of Non-Emergent Request for Health Services; GEO Request for Health Services Form HS-154. Detainees submit sick call request through a kiosk located in each dorm. Sick call request are reviewed and triaged by the nurse within 24 hours.						
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	11/15/2018	
Clinical (c)							
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
cUC-2	Was care delivered within the scope of the nurse's license?						
cUC-3	Were vital signs documented during the nurse's assessment?						
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
Total Applicable:			10	10	10	5	5
Total Met:			10	10	10	5	5
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
1	(b)(6); (b)(7)(C)	skin infection	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
2		knee pain	Yes	Yes	Yes	Yes	Yes
3		migraine	Yes	Yes	Yes	Yes	Yes
4		throat pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
5		ankle pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
6		wound	Yes	Yes	Yes	Yes	Yes
7		heartburn	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
8		back pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
9		rash	Yes	Yes	Yes	Yes	Yes
10		tooth pain	Yes	Yes	Yes	Yes	Yes

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DENTAL CARE

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	NA
5		YES	YES	YES	YES
6		YES	YES	YES	NA
7		YES	YES	YES	YES
8		YES	YES	YES	NA
9		YES	YES	YES	NA
10		YES	YES	YES	NA
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

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DENTAL CARE

DATE 1/22/18 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

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DENTAL CARE

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	NA
8		YES	YES	YES	NA
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	6 / 6 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

August 29, 2018

MEMORANDUM FOR: (b)(6); (b)(7)(C)
ERO Assistant Director
ICE Health Service Corps

FROM: (b)(6); (b)(7)(C)
IHSC Field Medical Coordinators-Denver Field Office

(b)(6); (b)(7)(C)
IHSC Field Medical Coordinators-Seattle Field Office

THROUGH: (b)(6); (b)(7)(C)
Acting Deputy Assistant Director – Health Care Compliance
ICE Health Service Corps

(b)(6); (b)(7)(C)
Medical Case Management Unit Chief
ICE Health Service Corps

(b)(6); (b)(7)(C)
Western Regional Field Medical Coordinator
ICE Health Service Corps

SUBJECT: Denver Contract Detention Facility (DCDF) Supplemental Criteria Site Visit Review April 24 – 26, 2018

Purpose

On April 24 – 26, 2018 (b)(6); (b)(7)(C) conducted a Field Medical Coordinator (FMC) site visit to DCDF to determine compliance with the ICE 2011 Performance Based National Detention Standards (PBNDS) and to review the IHSC Quality of Care (QOC) tools. The FMCs also reviewed the findings from the Office of Detention Oversight (ODO) and IHSC Investigative Unit (IIU) mortality reviews for detainee (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) These reviews were conducted in January 2018 and reviewed current DCDF practice related to the findings. The purpose of this memo is to provide an update regarding DCDF's progression made to address the ODO and IIU mortality review findings.

1. Receiving screening. (IIU finding)

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National Commission on Correctional Health Care (NCCHC): Standards for Health Services in Jails, 2014: J-E-02, *Receiving Screening*.
• PBNDS 2011: 4.3, *Medical Care;* section V.J, *Medical and Mental Health Screening of New Arrivals*.
• PBNDS 2011: 4.3, *Medical Care;* section V.A.2, *General*
Findings:
• Receiving screening did not take place as soon as possible upon arrival to the facility.
• Receiving screening was completed five (5) hours and 28 minutes after arrival to the facility.
Current Findings as of 4/24-26/2018: The medical staff and GEO Intake Officers reported completing a Receiving Screening on all new arrivals but Receiving Screening documentation was not available. During this site visit, GEO medical/intake staff reported that they will immediately document on the I-213/I-216 accompanying new arrivals the time, date and sign reporting when new intake Receiving Screenings are completed. At this time, this process will serve as documentation that a Receiving Screening was completed on new arrivals. GEO reported that they separate arriving detainees into two groups: 1) to be seen first due to medical problems and 2) no medical problems. However, there is no evidence provided or demonstrated during the site visit that this is being completed. The FMC will continue to follow-up on these issues at the next FMC site visit.

2. Initial health assessment. (IIU and ODO finding)
NCCHC 2014: J-E-04, *Initial Health Assessment*.
• Performance-Based National Detention Standards (PBNDS), 2011: 4.3, *Medical Care;* section V.J, *Medical and Mental Health Screening of New Arrivals*.
• PBNDS 2011: 4.3, *Medical Care;* section V.M., *Comprehensive Health Assessment*.
Findings:
The detainee's initial health assessment was not completed within two working days or 14 days.
• In review of the ICE detainee health assessment log, a total of 180 initial health assessments were past due.
Current Findings as of 4/24-26/2018: All initial Health Assessments reviewed were in compliance with PBNDS Standards.

3. Chronic disease services. (IIU finding)
NCCHC 2014: J-E-04, *Initial Health Assessment*.
• PBNDS 2011: 4.3, *Medical Care*; section V.J, *Medical and Mental Health Screening of New Arrivals*.
Findings:
• Although the DCDF physician ordered baseline laboratory tests during intake, there is no documentation of an initial assessment, follow-up evaluation, or treatment plan established.
• An APP or physician did not review the detainee's serial blood pressure results.
• An APP or physician did not review the detainee's laboratory results in a timely manner.
• The DCDF physician did not evaluate or adjust the detainee's treatment plan. [*Investigator's note: On November 27, the physician reviewed and signed off on the detainee's laboratory results.*]
• During the site visit [January 18-19, 2018], there were 64 ICE detainees in custody with varying chronic conditions. Due to the limited time constraints, the investigators were unable to determine if an APP or physician followed each detainee's condition in a timely manner and if an individualized treatment plan was established.
Current Findings as of 4/24-26/2018: The new Clinical Director (CD), who started on March 5, 2018, evaluated all but five chronic care detainees within the first week of being on duty to establish a baseline. The five remaining chronic care detainees had been evaluated by the previous CD within the previous 30 days. The new CD plans to follow up with these five detainees prior to the required 90-day chronic care follow up. All new arrivals reporting chronic care issues are being evaluated by the

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CD or APP within the required 2 business days of arrival. The CD and APP reviewed all the charts and signed off all the unsigned labs/intakes/physicals/etc. A new lab result reporting process was implemented prior to this site visit which should be an improvement over the previous lab result reporting system. This lab reporting update includes a direct line so the lab company can call medical directly and report a critical lab value to the charge nurse or provider. The nurse then notifies the provider of any critical labs who will provide further instructions if needed.

4. Oral care. (IIU and ODO finding)
NCCHC 2014: J-E-06, *Oral Care.*
• PBNDS 2011: 4.3, *Medical Care*; section V.R, *Dental Treatment.*
Findings:
• Initial oral screening was not completed within 14 days of admission.
Current Findings as of 4/24-26/2018: Oral and dental screenings were completed during the 14 day physicals.

5. Continuity and coordination of care during incarceration. (IIU and ODO finding)
NCCHC 2014: J-E-12, *Continuity and Coordination of Care During Incarceration.*
• PBNDS 2011: 4.3, *Medical Care*; section V.K, *Substance Dependence and Detoxification.*
Findings:
During the detainee's detention, there is no evidence supporting a physician's review of the medical record. In addition, there were no multi-disciplinary (medical, mental health, nursing, or custody) coordination of care to help improve the detainee's clinical outcome**.**
• An APP or physician did not review diagnostic tests in a timely manner. • Treatment plans were not initiated or modified as clinically indicated based on the detainee clinical presentation.
• The detainee was not referred to an appropriate facility qualified to provide treatment and monitoring for opiate withdrawal.
Current Findings as of 4/24-26/2018: The new CD and APP are reviewing, coordinating, referring and providing appropriate follow up care as needed. The CD and APP reviewed all the charts and signed off all the unsigned labs/intakes/physicals/etc. As of this site visit, recent diagnostic tests are being reviewed within a timely manner. Chronic care treatment plans were initiated and placed in the charts. Referrals to outside specialty care are being completed.

6. Medical diet and nutritional caloric intake. (IIU finding)
NCCHC 2014: J-F-02, *Medical Diet.*
• PBNDS 2011: 4.2 *Hunger Strike*; section II.1, *Expected Outcomes.*
• PBNDS 2011: 4.2 *Hunger Strike*; section II.C, *Initial Medical Evaluation and Management.*
• PBNDS 2011: 4.2 *Hunger Strike*; section II.D, *Food and Liquid Intake and Output.*
Findings:
• An APP or physician did not order the detainee a medical diet.
• During the detainee's detention, medical/nursing staff did not initiate monitoring of: laboratory testing, weight checks, intake and output monitoring. The clinical medical authority (CMA) did not consult with the facility administrator to initiate monitoring of food and water intake by assigned custody officers.
• Although the detainee refused meals up to 72 hours or more, there was no documentation of referrals for nutritional counseling and/or an evaluation for a possible hunger strike.
Current Findings as of 4/24-26/2018: During this visit, there were no hunger strike charts for review since the previous FMC site visit in January 2018 available for review. (One declared hunger strike ended the first day after hunger strike protocol was initiated.) Many chronic care detainees had documented medical diet forms in the medical charts. Though current DCDF hunger strike policies and procedures meet the PBNDS and NCCHC, a review to assess

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appropriate care and documentation will need to be deferred until a hunger strike situation occurs and the post hunger strike medical chart can be reviewed.

7. Prescribing continuity medications upon intake into DCDF. (IIU and ODO finding)
NCCHC 2014: J-E-02, *Receiving Screening*.
• PBNDS 2011: 4.3 *Medical Care*; section V.U.5, *Delivery of Medication*.
• The GEO group, Inc.; Clinical Practice Guidelines: *Detoxification of Chemically Dependent Inmates/Detainees/Residents (I/D/R)*, August 2014, page 14, *Opiate Withdrawal*.
• The GEO group, Inc.: Policy 902, *Alcohol and Drug Assessment and Treatment*, September 9, 2016.
Findings:
The DCDF physician's efforts were limited to searching Epic Care link.org (web based application allowing authorized physicians to access their patient's medical records in real time. All local clinics/hospitals who provide indigent care are linked into this system). The physician did not request additional information from the detainee or ICE regarding family member(s)' contact information to clarify his medical history.
• The detainee reported a history of taking prescribed medications (methadone); however, an APP or physician did not evaluate him as soon as possible, but no later than 24 hours after arrival. The physician did not conduct a medication reconciliation with the detainee.
• The DCDF physician's orders were based on management of alcohol withdrawal versus opioid withdrawal (methadone).
Current Findings as of 4/24-26/2018: 100% of charts reviewed had medication ordered within 24 hours of arrival and first dose of medication given within 24 hours of the order. For two charts reviewed, the detainee could not remember the name of the medication he was taking; the nurse called the pharmacy the detainee provided and clarified the medications.

8. Alcohol and other drug problems. (IIU and ODO finding)
NCCHC 2014: J-G-06, *Patient with Alcohol and Other Drug Problems*.
• PBNDS 2011: 4.3, *Medical Care*; section V.K, *Substance Dependence and Detoxification*.
• The GEO group, Inc.; Clinical Practice Guidelines: *Detoxification of Chemically Dependent Inmates/Detainees/Residents (I/D/R)*, August 2014, page 14, *Opiate Withdrawal*. • The GEO group, Inc.: Policy 902, *Alcohol and Drug Assessment and Treatment*, September 9, 2016.
Findings:
• The DCDF physician did not order the correct medication to manage withdrawal symptoms, based on clinical practice guidelines.
DCDF medical staff were not aware of GEO's policies and procedures on alcohol and drug withdrawal management.
• DCDF custody staff did not receive training on recognizing alcohol and other drug problems.
• The CMA did not establish guidelines for evaluation and treatment for detoxification.
Current Findings as of 4/24-26/2018: Though current DCDF Alcohol and Drug Assessment and Treatment policies and procedures meet the PBNDS and NCCHC, a review to assess appropriate care and documentation will need to be deferred until an alcohol and/or drug detoxification situation occurs and the post alcohol/drug treatment medical chart can be reviewed. During this site visit, GEO medical was developing training guidelines to provide to medical and custody staff that included alcohol and other drug withdrawal management training. Alcohol/drug treatment for detoxification guidelines were established by the new CD. On 4/30/2018, a detainee showing symptoms of alcohol withdrawal upon intake was sent to the emergency room and stabilized. On 7/2/2018, the HSA stated training had been conducted, and new guidelines have been initiated. Detaienees suffering from withdrawal from alcohol will be housed in medical and a CIWA score will be completed as indicated. Any detainee who is severely withdrawing will be sent out to the hospital via ambulance for an evaluation and detoxification.

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9. Intoxication and withdrawal. (IIU and ODO finding)
NCCHC 2014: J-G-07, *Intoxication and Withdrawal.*
• PBNDS 2011: 4.3, *Medical Care*; section V.K, *Substance Dependence and Detoxification.*
• The GEO group, Inc.; Clinical Practice Guidelines: *Detoxification of Chemically Dependent Inmates/Detainees/Residents (I/D/R)*, August 2014, page 14, *Opiate Withdrawal.*
• The GEO group, Inc.: Policy 902, *Alcohol and Drug Assessment and Treatment*, September 9, 2016.
Findings:
• DCDF did not follow GEO policy 902, stating inmates/detainees/residents (I/D/R) on methadone and or similar substances will immediately be referred to a facility qualified to address such needs.
• The physician did not follow GEO's clinical guidelines or document alternate treatment plans that justifications his deviation from the clinical guidelines.
• The physician did not establish protocols for assessment, monitoring, and management of symptoms of withdrawal.
• DCDF's nursing staff were not provided with training to manage withdrawal symptoms, conduct standard assessments at appropriate intervals, or how to identify and use the appropriate monitoring tools for drug withdrawal.
Current Findings as of 4/24-26/2018: This finding is covered in the Alcohol and other Drug problems section.

10. Access to emergency medical services. (IIU finding)
NCCHC 2014: J-A-07, *Emergency Response Plan.*
• PBNDS 2011: 4.3, *Medical Care*; section T.2, *Emergency Medical Services and First Aid.*
• The GEO group, Inc.: Policy 608-B, *Emergency Services*, April 1, 2017.
Findings:
• The detainee's access to EMS was delayed because nurse/custody staff did not immediately identify and call 911; instead, the physician and HSA were called to obtain prior approval to transfer the detainee to the hospital.
• The detainee's access to EMS was delayed because nurse/custody staff did not assess the detainee's condition or initiate CPR in a timely manner.
• DCDF medical staff are not certified through a CPR- BLS certifying body for health care providers. DCDF medical staff are certified under the American Safety and Health Institute (ASHI) CPR/AED/first aid program. [*Investigator's note: ASHI CPR/AED/first aid intended audience are individuals who are not health care providers or professional rescuers but desire or are required to be certified in basic emergency medical care, including CPR and the use of an AED.*]
• During the site visit, investigators found mass disaster and man-down drills are not critiqued, the results were not shared with all health care staff, and recommendations for health staff were not developed or acted upon.
• The DCDF HSA did not ensure that medical staff were competent in implementing the facility's emergency plan, to include recognizing signs of potential health emergencies and the required responses: administering CPR and securing transfer of detainee to appropriate hospital.
Current Findings as of 4/24-26/2018: Staff have been instructed that during a medical emergency to initiate emergency services without delay and notify the HSA and CD of the situation. All medical staff have received American Heart Association CPR training. The new HSA is developing a training plan that will include implementing the facility's emergency plan, recognizing potential health emergencies and required responses. This was in progress during this site visit but will require further compliance evaluation during the next planned FMC site visit. Mass disaster and man-down drills were not reviewed during this site visit. This will be evaluated during the next planned FMC site visit.

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11. Professional development. (IIU finding)
2014: J-C-03, *Professional Development.*
• PBNDS 2011: 4.3, *Medical Care*; section V.B, *Designation of Authority.*
Findings:
• DCDF medical staff, who have patient contact, are not currently certified through a CPR- BLS certifying body for health care providers. Medical staff are certified under ASHI CPR/AED/first aid program. In 2015, the medical staff changed sponsors from Red Cross CPR/first aid.
Current Findings as of 4/24-26/2018: All medical staff have received American Heart Association CPR training since the last FMC visit in January 2018.

12. Patients with special health needs. (IIU and ODO finding)
NCCHC 2014: J-G-02, *Patients with Special Health Needs.*
• PBNDS 2011: 4.3, *Medical Care*; section V.N, *Medical/Psychiatric Alerts and Holds.*
• PBNDS 2011: 4.3, *Medical Care*; section V.W, *Special Needs and Close Medical Supervision.*
• NDS 2011: 4.3, *Medical Care*; section V. X, *Notification of Detainees with Serious Illnesses and other Specified Conditions.*
Findings:
• An initial assessment was not completed for special needs.
• The detainee was not listed on the special needs log or the SDI logs. The special needs treatment plan was not filed in the detainee's health care record.
• The DCDF medical unit does not maintain a list of special needs patients.
• An individualized treatment plan addressing all of the detainee reported conditions was not developed.
• A medical/psychiatric alert was not initiated; therefore, the facility administrator did not receive notice of the detainee's condition, and did not notify the responsible ICE agent, in a timely manner.
• The facility administrator and CMA did not ensure that the Field Office Director was notified as soon as practical of the serious physical condition [e.g., *any condition that caused repeated loss of consciousness; any chronic deteriorating condition requiring multiple medications*].
Current Findings as of 4/24-26/2018: During this visit, there were no special needs detainees since the previous FMC site visit in January 2018 available for review. The HSA provided a log of special needs detainees. On 5/7/2018, the facility received a special needs detainee (deaf, illiterate, no sign language). A medical/psychiatric alert was initiated and ERO/ICE was notified immediately.

13. Basic mental health services. (IIU finding)
NCCHC 2014: J-G-04, *Basic Mental Health Services.*
• PBNDS 2011: 4.3, *Medical Care*; section V.O, *Mental Health Program.*
Findings:
• DCDF did not provide the detainee appropriate and timely access to mental health services.
• After his initial mental health evaluation by a psychiatrist, the detainee was not seen again until eight days later by a psychologist.
• Throughout the course of the detainee's DCDF detention, he repeatedly informed nursing and mental health staff of his progressively debilitating withdrawal symptoms.
• Although several MHPs saw the detainee there was no coordination of care amongst the MHPs or with the MHPs and the physician.
• The detainee was initially started on the CIWA tool for monitoring the progression of his symptoms versus the COWS tool, which is more applicable for a patient experiencing opiate withdrawal symptoms. On November 29, 2017, the psychiatrist adjusted the detainee's treatment plan to facilitate an improved clinical outcome.

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• During the detainee's detention, the MHPs did not consider transferring the detainee to a facility that could appropriately manage his condition.
Current Findings as of 4/24-26/2018: 100% of charts reviewed that identified a mental health illness upon intake were referred and seen by a mental health provider in a timely manner.

14. Sufficient number and appropriately trained medical/nurse staffing. (IIU and ODO finding)
NCCHC 2014: J-C-07, *Staffing*.
• PBNDS 2011: 4.3, *Medical Care*; section V.B, *Designation of Authority*.
• The referenced contract is HSCEDM-11-R-00002 *Contractor-owned/Contractor-operated Detention Facility (Denver area) Final Proposal Revision (FPR) and Additional Final Responses*, dated August 24, 2011.
Findings:

(b)(7)(E)

• While it is not possible to specify exact clinician-to-patient ratios, the amount of prescribing provider time must be sufficient to prevent reasonable delays in patients (i.e., detainees) receiving appropriate, timely, and necessary care. One physician was not sufficient to provide appropriate clinical and administrative services to this population.
• DCDF's administrative and health authorities did not routinely assess the adequacy and sufficiency of the staffing plan necessary to meet the needs of the population. The assessment should have included, but not limited to: full-time equivalent (FTE) staff coverage required; a list of current staff and vacancies, and; a plan to address how full coverage would be accomplished, if not met.
Current Findings as of 4/24-26/2018:

(b)(7)(E)

15. Medical autonomy. (IIU finding)
NCCHC 2014: J-A-03, *Medical Autonomy*.
• PBNDS 2011: 4.3, *Medical Care*; section V.B, *Designation of Authority*,
• HSCEDM-11-R-00002 *Contractor-owned/Contractor-operated Detention Facility (Denver area)* - GEO Job Description – *Physician; Primary Duties and Responsibilities*, March 2011.
Findings:
• DCDF CMA's decisions and implementation of appropriate and timely care were not conducted in an effective and safe manner.

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• During the site visit, there were 64 ICE detainees in custody with varying chronic conditions, but due to the limited time constraints, the investigators were unable to determine if the provider followed each detainee's condition in a timely manner and if an individualized treatment plan was established.
• Administrative decisions (such as utilization review, performance improvement) are not coordinated, if necessary, with clinical needs so the patient care is not jeopardized.
• A process for chronic disease utilization review and performance improvement has not been implemented.
• The designated CMA did not exercise his overall responsibility for medical clinical care pursuant to ICE-GEO's written award contract,

- GEO's physician job description states:
  - Performs routine medical examinations on detainees/inmates referred by the nursing/professional staff under established guidelines. Provides medical treatment and orders studies, tests and ancillary services required consistent with the provision of basic health care services.
  - Documents all services provided in the detainee/inmate medical record.
  - Reviews regularly those cases requiring ongoing medical/pharmaceutical attention.

  Initiates and maintains compliance with company policy and reviews all other policies and procedures annually to assure their compliance with the American Correctional Association and/or National Commission Standards for Correctional Health Care.

Current Findings as of 4/24-26/2018: The new CD, who started on March 5, 2018, evaluated all but five chronic care detainees within the first week of being on duty to establish a baseline. The five remaining chronic care detainees had been evaluated by the previous CD within the previous 30 days. The new CD plans to follow up with these five detainees prior to the required 90-day chronic care follow up. All new arrivals reporting chronic care issues are being evaluated by the CD or APP within the required 2 business days of arrival. The CD and APP reviewed all the charts and signed off all the unsigned labs/intakes/physical/etc. Appropriate and timely follow care by the CD and APP were documented.
The HSA was in the process of designing and implementing a CQI program to identify and monitor issues. To ensure compliance, this finding will require follow up during a future FMC site visit.
The CD was in the process of reviewing GEO policy. She has already developed supplemental chronic care forms in addition to the standard GEO chronic care forms.
On 7/2/2018, the HSA stated the CQI program has been established and has conducted meetings for April, May and June.

16. Policies and procedures. (IIU finding)
NCCHC 2014: J-A-05, *Policy and Procedures.*
Findings:
• DCDF medical/nursing staff were not familiar with the three levels of policies: corporate, national, and local.
• DCDF medical/nursing staff did not review all policies on an annual basis.
Current Findings as of 4/24-26/2018: This requires medical/nursing staff documented training and review of the training material. The HSA was in the process of designing and implementing a training plan to incorporate these topics. To ensure compliance, this finding will require follow up during a future FMC site visit (tentively scheduled for October 2018).

17. CQI program. (IIU finding)
NCCHC 2014: J-A-06, *Continuous Quality Improvement Program.*

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• PBNDS 2011: 4.3, *Medical Care*; section V.EE.2, *Health Care Internal Review and Quality Assurance*.
Findings:
• DCDF does not have a CQI program that identifies health care aspects to be monitored; i.e., chronic disease, health assessments, sick call, documentation, etc. DCDF's health authority has not established a quality improvement committee with representatives from the major program areas.
When system and clinical issues (i.e., delay in completing health assessments), delay in chronic disease management, staffing, etc., were identified, the DCDF's HSA or CMA did not develop a process(s) for corrective action, to include, but not limited to development of process and/or outcome studies.
Current Findings as of 4/24-26/2018: The HSA was in the process of designing and implementing a CQI program to identify and monitor issues. To ensure compliance, this finding will require follow up during a future FMC site visit.

18. Communication on patient's health needs. (IIU finding)
NCCHC 2014: J-A-08, *Communication of Patients' Health Needs*.
• PBNDS 2011: 4.3, *Medical Care*; section V.BB.2, *Confidentiality and Release of Medical Records*.
Findings:
• DCDF's custody staff are not advised of special health needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions.
• DCDF's clinical health authority does not routinely communicate with the facility administrator, ICE or designated staff regarding the detainee's deteriorating condition.
Current Findings as of 4/24-26/2018: DCDF administration staff is notified via email of any significant illness, mental illness, suicide watch, hunger strike and detainees placed in the medical housing unit. A weekly meeting between ICE and GEO administration takes place and updates are given on these detainees. The new HSA is providing regular updates via email to GEO administration and ICE staff.

19. Health training for correctional officers. (IIU finding)
NCCHC 2014: J-C-04, *Health Training for Correctional Officers*.
• PBNDS 2011: 7.3, Staff Training; section V.A, *Overview of Training*.
• PBNDS 2011: 7.3, Staff Training; section V.B, *Initial Orientation*.
• PBNDS 2011: 7.3, Staff Training; section V.C, *Initial and Annual Training*.
Findings:
• DCDF's custody staff did not receive health-related training at least every two years for recognizing acute manifestations of intoxication and withdrawal and signs and symptoms of mental illness.
• DCDF's facility administrator did not ensure that the facility conducted appropriate orientation, initial and training for all staff and contractors consistent with this standard and with appropriate assessment measures.
• DCDF's professional and support employees, including contractors, who have regular or daily detainee contact, were not provided training related to detainees with disabilities and special needs, to include mental illness, drug or alcohol abuse, and/or withdrawals.
Current Findings as of 4/24-26/2018: This requires custody staff documented training and review of the training material. The HSA is in the process of designing and implementing a training plan to incorporate these topics. To ensure compliance, this finding will require follow up during a future FMC site visit.

20. Training/education for medical staff. (IIU finding)
PBNDS 2011: 7.3, *Staff Training*; section V. A, Overview of Training.
• PBNDS 2011: 7.3, *Staff Training*; section V.C, Initial and Annual Training, and

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• PBNDS 2011: 4.2, *Hunger Strike*; section V.A.B, Initial Referral.
• PBNDS 2011: 4.6, *Significant Self-harm and Suicide Prevention and Intervention*; section V. A, *Staff Training*.
Findings:
• DCDF's HSA did not ensure that all staff and contractors received appropriate orientation, initial and annual training consistent with standards and with appropriate assessment measures.
• DCDF's professional and support employees, including contractors, who have regular or daily detainee contact were not provided training related to detainees with disabilities and special needs, health related emergencies, and hunger strike.
• All staff are not provided with initial and annual training to recognize the signs of a hunger strike and when to implement the referral process for medical assessment and management.
Current Findings as of 4/24-26/2018: This requires medical/nursing staff documented training and review of the training material. The HSA is in the process of designing and implementing a training plan to incorporate these topics. To ensure compliance, this finding will require follow up during a future FMC site visit.

21. Medication Services. (IIU and ODO finding)
NCCHC 2014: J-D-02, *Medication Services*.
• PBNDS 2011: 7.3, *Staff Training*; section V.A, *Overview of Training*.
• PBNDS 2011: 4.3, *Medical Care*; section V.U.4, *Delivery of Medication*.
Findings:
• DCDF's medical staff did not administer the detainee's medications in a timely manner.
• Upon arrival to the facility, the detainee did not receive his prescribed medications, nor was a medical, reconciliation conducted.
Current Findings as of 4/24-26/2018: 100% of the 10 charts reviewed had medication ordered within 24 hours of arrival and first dose of medication given within 24 hours of the order. For two charts reviewed, the detainee could not remember the name of the medication he was taking. The nurse called the pharmacy the detainee provided and clarified the medications. MARs were noted to be documented within standards. No blank dates were noted, and minimal refusals, less than 5% were noted.

22. Nursing assessment and documentation. (IIU finding)
PBNDS 2011: 4.3, *Medical Care*; section V.B, *Designation of Authority*.
• NCCHC 2014: J-C-02, *Clinical Performance Enhancement*.
• Nursing Process (Nursingprocess.org) – Five step process to enhance the quality of patient care. (Assessment, Diagnosing, Planning, Implementing, and Evaluation Phases).
• Colorado *Nurse Practice Act*, section 12-38-111.
Findings:
• DCDF's medical staff have an up-to-date peer review on file; however, DCDF's nursing staff do not have a clinical performance process in place to evaluate the appropriateness of services delivered.
• DCDF's health services authority does not engage in decision making about the deployment of health resources and the day-to-day operations of the health services program.
• DCDF's nurses did not provide appropriate and succinct documentation in the detainee's medical record.
• The "practice of professional nursing" shall include the performance of such services as:
    - Evaluating health status through the collection and assessment of health data
    - Health teaching and health counseling
    - Providing therapy and treatment that is supportive and restorative to life and well-being either directly to the patient or indirectly through consultation with, delegation to, supervision of, or teaching or others

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- Executing delegated medical functions;
- Referring to medical or community agencies those patients who need further evaluation or treatment; and
- Reviewing and monitoring therapy and treatment plans.

Current Findings as of 4/24-26/2018: Overall, in the approximately 30 medical records reviewed, nursing documentation was thorough and appropriate. Medical housing unit nursing documentation was consistent on the medical observation nursing progress record. The HSA was notified about the lack of a nursing clinical performance process or peer review. To ensure that a review process has been implemented, this will require follow up during a future FMC site visit. The new HSA is very involved in the day-to-day operations of the medical clinic.

23. Diagnostic services. (IIU finding)

NCCHC 2014: J-E-02, *Continuity and Coordination of Care During Incarceration.*
• NCCHC 2014: J-D-04, *Diagnostic Services.*
• PBNDS 2011: 4.2, *Hunger Strike*; section V.E, *Refusal to Accept Treatment.*
Findings:
• Diagnostic results were not reviewed by the physician in a timely manner.
• The DCDF physician did not order follow up diagnostic testing, as the detainee's status deteriorated.
• DCDF medical staff did not conduct clinical and laboratory monitoring as necessary to possibly improve the detainee's clinical outcome; i.e., urine dipstick, fingerstick blood sugar, and/or weight check.
Current Findings as of 4/24-26/2018: The new CD and APP reviewed all the charts and signed off all the unsigned labs/intakes/physical/etc. Based on ten chart reviews using the IHSC Quality of Care audit tool, individuals have received timely diagnostic testing as ordered by the medical providers. The medical providers reviewed test results timely, and nursing staff follow orders written as indicated. New arriving detainees reporting diabetes receive fingerstick blood sugar testing during the intake and are scheduled to see the medical provider within 2 business days. The medical staff are completing urine dipsticks, finger stick blood sugars etc., as ordered by the physician.

24. Medical observation/infirmary care. (IIU and ODO finding)

NCCHC 2014: J-G-03, *Infirmary Care.*
• PBNDS 2011: 4.3, *Medical Care*; section V.F. 3, *Medical Housing.*
The GEO group, Inc.: Policy 905-A, Medical Observation
Findings:
• Infirmary care was not appropriate to meet the serious medical needs of a patient.
• DCDF did not provide appropriate staffing to meet the requirements of the standard.
• DCDF medical/nursing staff did not provide the appropriate frequency of rounds.
• DCDF nursing staff are inappropriately assigned to observation/infirmary and other duties, resulting in nurses leaving the observation/infirmary area throughout the shift.
• The physician's orders did not include the admission diagnosis, medication, diet, activity restrictions, diagnostic tests required, and/or follow-up care.
• During a detainee's detention, the physician did not document any care delivery provided.
• DCDF's nursing staff inconsistently documented care delivery and consistency of forms were not utilized.
Current Findings as of 4/24-26/2018: A nurse, usually the charge nurse, was assigned to the medical housing unit. No other duties are assigned to the MHU nurse. The MHU rooms are next to the nursing station and is not a separate unit. Nursing documentation was consistent on the medical observation nursing progress record. The physician or the physician assistant documents daily and include diagnosis, medications, and treatment plan to include activities, diagnostics and

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follow-up care. Diet orders were not consistently documented; the FMC will review this during the next FMC site visit.

25. Shift sharps/narcotic counts. (IIU finding)
NCCHC 2014: J-D-01, *Pharmaceutical Operations*.
• PBNDS 2011: 1.2, *Environmental Health and Safety*; section D, 1, *Needles and Sharp Objects*.
• PBNDS 2011: 2.14, *Tool Control*; section II, 1, *Expected Outcomes*.
• PBNDS 2011: 2.14, *Tool Control*; section H, *Storage in Work Areas*.
Findings:
• DCDF's nursing staff do not perform end-of-shift sharps/narcotic count with the oncoming nurse counting and the outgoing nurse verifying in accordance with safe community practices.
Current Findings as of 4/24-26/2018: Documentation reviewed noted that the sharps/narcotic count was completed together by an oncoming and outgoing nurse to verify in accordance with safe community practices.

26. On-call provider. (ODO finding)
PBNDS 2011: *Medical Care*; section V.T, *Emergency Medical Services and First Aid.*
• RNs reported difficulty reaching the physician after hours.
Current Findings as of 4/24-26/2018: Currently the physician and PA rotate on-call weeks. If staff are unable reach the on-call provider, they contact the other provider. There were no documented or reported issues regarding contacting the on-call providers.

27. Psychotropic medication informed consent. (ODO finding)
PBNDS 2011: *Medical Care*; section V.AA, Informed Consent and Involuntary Treatment.
• An informed consent specific to the anti-depressant/sedative Trazadone was not completed and signed by the detainee.
Current Findings as of 5/23/2018: Ten detainee charts containing psychotropic medications were reviewed. All 10 charts (100%) had consent forms signed by the detainee and provider that explained the risk and side effects specific to the medication.

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
08/23/2019	03/25/2019	Denver Contract Detention Center (DCDC)

Name of Reviewer: (b)(6); (b)(7)(C)

Area of Responsibility/Field Office: Denver Field Office

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☒ ACA ☒ NCCHC ☒ Other: PBNDS 2016 Revisions.

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
1,277	1,113	164	3	1

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
2	0	0	0	0	2

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)	Phone Number: +1 (303) 739-(b)(6); (b)(7)(C)
Address: 3130 Oakland St. Aurora, CO 80010	Address: 3130 Oakland St. Aurora, CO 80010

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Current Site visit findings 8/23/2019: No findings noted.

Previous Site visit findings 3/25/2019.
19 of 23 (83%) grievances was answered within 5 working days.
- PBNDS Standard Grievance System 6.2 V.4 ensure a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable. Repeat finding.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
80	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Current Site visit findings 8/23/2019: No findings noted.
GEO group chronic care guidelines are based on the Bureau Of Prisons guidelines.

Previous site visit findings 3/25/2019
16 of 18 (89%) Detainee with a chronic condition was seen by a provider within two working days.
- NCCHC Standard; J-E-04, Initial Health Assessment. Inmates identified with clinically significant findings as the result of a comprehensive receiving screening receive an initial

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health assessment as soon as possible, but no later than 2 working days after admission.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Current site findings 8/23/19: No deficiencies noted.
DCDC policy reviewed; 614-A Hunger Strike

Previous site visit findings 3/25/2019: No deficiencies noted.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
6	17

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Current site visit findings 8/23/2019: No deficiencies noted.
DCDC policies reviewed; 907-C Suicide prevention and intervention.

Previous site visit findings 3/25/2019: No deficiencies noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

Current site visit findings 8/23/2019: No deficiencies noted.
DCDC policies reviewed; 604-B Advance Directive, Terminal Illness and End of Life Decision Making, 202-A Death of Inmate/Detainee/Resident, 210-Notification in Emergency or Death.
There have been no deaths since the previous site visit.

Previous site visit findings 3/25/2019: No deficiencies noted.

Other Observations

The FMC conducted this site visit on August 21-23, 2019. A total of 80 charts and 66 Medication Administration Records (MARs) were reviewed for this audit.
- The FMC focused on detainee charts that arrived after the last site visit to present.

--FACILITY DATA:
- DCDC is operated by the GEO Group, Inc., and it houses US Marshals and ICE detainees. The facility has a holding capacity of 976 detainees.
- An adjacent annex was opened on January 21, 2019 on a 90 day contract for an additional 432 beds. Discussions and contract proposals are all pending for possible continuation of use for the annex building.

--ACCREDITATIONS/INSPECTIONS:
- ACA - November 2016.
- PBNDS (Nakamoto Group)- September 2017.
- IHSC Investigative Unit, Mortality review. - January 2018.
- PREA Audit - April 2018, DOJ
- Civil Right and Civil Liberties - August 2018
- PREA Audit - October 2018, DHS
- NCCHC - October 2018
- Nakamoto - November 2018
- OIG - November 2018
- ODO April 16 -18, 2019
- GEO Corporate Audit - June 10 -14, 2019
- ACA Mock audit by Geo Corp August 20 - 22, 2019

--MEDICAL STAFFING:
See QMC toolkit.

(b)(7)(E)

--STAFFING VACANCIES:

(b)(7)(E)

AMERICAN OVERSIGHT

(b)(7)(E)

--MEDICAL CLINIC
- The medical clinic has eight medical housing unit rooms, five negative pressure rooms, and one suicide observation room.(b)(7)(E)
- There is a designated trauma/urgent care room which contains an urgent response cart, three AEDs, two gurneys, an eye wash shower, and other emergency supplies.
- The annex building contains three isolation rooms. The medical records and pill carts for detainees housed in the annex are located in the medical department in the annex.

--STAFF TRAINING:
- DCDC HSA conducts monthly staff meeting and training. Curriculum and training log were reviewed for registered nurse physical exam training, dental training, mental health training including intakes, referrals, and suicide watch, suicide risk assessment requirements. Training topics were reviewed and align with accreditation standards.

--SUPPLEMENTAL INFO:
- DCDC ICE detainees have access to interpretation services as needed. Language line contact information was noted in intake, dental and various other clinic exam rooms. Consent forms for interpretation was noted in non-English speaking charts.
- DCDC providers use the GEO Group Clinical Practice Guidelines which were adopted from the Bureau of Prisons (BOP) guidelines.

Deficiencies for Areas Evaluated

Site visit findings 8/23/2019: No findings.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC toolkit.

Health Assessment

See QMC toolkit.

Urgent Care (Sick Call)

See QMC toolkit.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC toolkit.

Medication Administration Practices

See QMC toolkit.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Continuity of Medication

See QMC toolkit.

Mental Health Screen

See QMC toolkit.

Medical Recordkeeping Practices

See QMC toolkit.

Pregnant Women

See QMC toolkit.

Dental Care

See QMC toolkit.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Acute Laboratory Testing

See QMC toolkit.

Diagnostic Services and Specialty Care Access

See QMC toolkit.

Mental Health Treatment Planning

See QMC toolkit.

Treatment of Disability

See QMC toolkit.

Complaints and Grievances

See QMC toolkit.

AMERICAN OVERSIGHT

ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC toolkit.

Human Immunodeficiency Virus (HIV)

See QMC toolkit.

Hypertension

See QMC toolkit.

Asthma

See QMC toolkit.

Seizure Disorder

See QMC toolkit.

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

(b)(7)(E)

Additional Comments

Continue to monitor for need to increase staff coverage when large trips are coming.
Electronic Health Records are coming to DCDC in September 2019; most of the staff are accustomed to this time of patient record.
Use of sticky notes for some notifications on paper charts can likely lead to that sticky note falling off of chart from lack of strong enough adhesive, please use tape to ensure adhesion.

AMERICAN OVERSIGHT

End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 815-(b)(6); (b)(7)(C)	Date Prepared: 08/26/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed:
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 01/09/2020

Recommendations:
(b)(5)

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 2-28-18 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? CHP

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4	Were lipids measured within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated?*
7	Was degree of control (goal GgbA1C<8.0) documented?
8	Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES	YES	YES	YES
2		NA	NA	NA	NA	NA	NA	NA	NA
3	Only 1 new	NA	NA	NA	NA	NA	NA	NA	NA
4	chart since	NA	NA	NA	NA	NA	NA	NA	NA
5	last visit	NA	NA	NA	NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	1 / 1 100%	1 / 1 100%	1 / 1 100%	1 / 1 100%	1 / 1 100%	1 / 1 10(%	1 / 1 100%	1 / 1 10(%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? GEO Group

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within the past 3 months? Were lipids measured
4	within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated? *
7	Was degree of control (goal HgbA1C <8.0) documented?
8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	NO	YES	YES	YES	YES	YES	YES
2		YES	NO	YES	YES	YES	YES	YES	YES
3		YES	NO	YES	YES	N/A	N/A	YES	YES
4		YES	YES	YES	YES	NO	N/A	YES	YES
5		NA	NO	YES	YES	N/A	N/A	YES	YES
6		YES	NO	N/A	N/A	N/A	YES	N/A	YES
7		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10		NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Total	5 /5 100 %	1 / 6 17 %	5 / 5 100 %	5 / 5 100 %	2 /3 67 %	3 3 100 %	5 /5 100 %	6 / 6 100 %

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? GEO Group

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4	Were lipids measured within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated?*
7	Was degree of control (goal GgbA1C<8.0) documented?
8	Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NA	NA	YES	YES
2		YES	YES	YES	YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES	YES	YES	YES
4		YES	YES	YES	YES	NA	NA	YES	YES
5		YES	YES	YES	YES	NA	YES	YES	YES
6		NA	NA	NA	NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	5 /5 100%	5 /5 100%	5 /5 100%	5 /5 100%	2 /2 100%	3 /3 100%	5 /5 100%	5 /5 100%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 04/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	YES	YES	N/A	YES
2		OB/Gyn	YES	YES	YES	YES
3		Other	YES	YES	N/A	YES
4		Other	YES	YES	N/A	YES
5		Other	NO	N/A	N/A	N/A
6		Other	NO	N/A	N/A	N/A
7		Other	NO	N/A	N/A	N/A
8		Other	NO	N/A	N/A	N/A
9		Other	NO	N/A	N/A	N/A
10		Other	NO	N/A	N/A	N/A
		Total	4 / 4 100%	4 / 4 100%	1 / 1 100%	4 / 4 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1 Was there a documented time urgency included on the order for specialty care or diagnostic services?
2 Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3 Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4 Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	OB/Gyn	YES	N/A	N/A	N/A
2		Other	YES	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Other	YES	YES	N/A	YES
5		Other	YES	YES	N/A	YES
6		Other	YES	YES	N/A	YES
7		Other	YES	YES	N/A	YES
8		Infectious Disease	YES	N/A	N/A	N/A
9		Other	YES	YES	N/A	YES
10		Other	NO	N/A	N/A	N/A
		Total	9 / 9 100%	7 / 7 100%	0 / 0 NA %	7 / 7 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 06/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	YES	YES	N/A	YES
2		Other	YES	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Other	YES	YES	N/A	YES
5		Infectious Disease	YES	YES	N/A	YES
6		Opthalmology	YES	YES	YES	YES
7		General Surgery	YES	YES	N/A	YES
8		Other	NO	N/A	N/A	N/A
9		Other	NO	N/A	N/A	N/A
10		Other	NO	N/A	N/A	N/A
		Total	7 / 7 100%	7 / 7 100%	1 / 1 100%	7 / 7 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	bells palsy	YES	NO	YES	YES	YES
2		shortness of breath	YES	NO	YES	YES	YES
3		arm infection	YES	NO	YES	YES	YES
4		withdrawals	YES	NO	YES	YES	YES
5		testicular pain	YES	NO	YES	YES	YES
6		anxiety	YES	NO	YES	YES	YES
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			6 / 6 100 %	0 / 6 0 %	6 / 6 100 %	6 / 6 100 %	6 / 6 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002514

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item #	Measure
1	Is there an outbound progress note?
2	*Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3	Is there discharge documentation from the hospital or ED in the chart?
4	Is there an inbound assessment?
5	Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	abdominal pain	YES	NO	YES	YES	YES
2		abd pain/appendix	YES	NO	YES	YES	YES
3		abdominal pain	YES	NO	YES	YES	YES
4		abnormal EKG/syncope	YES	NO	YES	YES	YES
5		stitches	YES	NO	YES	YES	YES
6			NO	NO	NO	NA	NA
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			5 / 5 100 %	5 / 5 100 %	5 / 5 100 %	5 / 5 100 %	5 / 5 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised September 2016

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002515

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	fall/laceration	YES	NO	YES	YES	YES
2		finger injury	YES	NO	YES	YES	YES
3		rectal bleeding	YES	NO	YES	YES	YES
4			NO	NO	NO	NA	NA
5			NO	NO	NO	NA	NA
6			NO	NO	NO	NA	NA
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002516

HEALTH ASSESSMENT

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	NA	YES
5		YES	YES	NA	NA	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	NA	YES
8		YES	YES	YES	NA	YES
9		YES	YES	NA	NA	YES
10		YES	YES	YES	NA	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	NO	NO
4		YES	YES	NA	NO	NO
5		YES	YES	YES	YES	YES
6		YES	YES	NA	NA	YES
7		YES	YES	YES	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	/ %	/ %	/ %	/ %	/ %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	NA	YES
5		YES	YES	NA	NA	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	NA	NA	YES
10		YES	YES	NA	NA	YES
	Total	20 / 20 100 %	20 / 20 100 %	3 / 3 100 %	3 / 3 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	NA	NO
5		YES	YES	NA	NA	NO
6		YES	YES	NA	NA	YES
7		YES	YES	NA	NA	NO
8		YES	YES	NA	NA	NO
9		YES	YES	NA	NA	NO
10		YES	YES	NA	NA	YES
	Total	20 / 20 100 %	20 / 20 100 %	3 / 3 100 %	7 / 9 78 %	13 / 20 65 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	20 / 20 100 %	1 / 1 100 %	20 / 20 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV CHP

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	No new	Patient Interview	NO	NO	YES	YES	YES
2	charts since	Recent Lab	NA	NA	NA	NA	NA
3	last visit	Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		0 / 1 0 %	0 / 1 0 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002523

CHRONIC DISEASE – HIV

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV GEO Group

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Patient Interview	YES	NA	YES	NA	YES
2		Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		1 / 1 100 %	0 / 0 NA %	1 / 1 100 %	0 / 0 NA %	1 / 1 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002524

CHRONIC DISEASE – HIV

DATE 6/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV GEO/CDC

Item #	Measure
1	How was HIV status identified? By laboratory, prior medical records or patient report?
2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4	Was antiretroviral treatment considered and documented?
5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Medical Record	YES	NA	YES	NA	YES
2		Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		1 / 1 100 %	/ NaN %	1 / 1 100 %	/ NaN %	1 / 1 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002525

CHRONIC DISEASE – HYPERTENSION

DATE 04/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? CHP

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	N/A	YES
3		YES	YES	N/A	YES
4		YES	YES	N/A	YES
5		NO	N/A	N/A	N/A
6		NO	N/A	N/A	N/A
7		NO	N/A	N/A	N/A
8		NO	N/A	N/A	N/A
9		NO	N/A	N/A	N/A
10		NO	N/A	N/A	N/A
	Total	4 / 4 100 %	4 / 4 100 %	1 / 1 100 %	4 / 4 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 01/22/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? GEO Group

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	NO	N/A	YES
2		YES	NO	N/A	YES
3		YES	NO	N/A	YES
4		YES	YES	YES	YES
5		YES	NO	N/A	YES
6		YES	YES	N/A	YES
7		YES	NO	N/A	YES
8		YES	YES	N/A	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	5 / 10 50 %	3 / 3 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 06/12/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? GEO GROUP

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	N/A	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	10 / 10 100 %	9 / 9 100 %	8 / 8 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 4/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Denver Contract Detention Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		NA	NO	NO	NO	NA
7		NA	NO	NO	NO	NA
8		NA	NO	NO	NO	NA
9		NA	NO	NO	NO	NA
10		NA	NO	NO	NO	NA
	Total	5 / 5 100 %	5 / 5 100 %	5 / 5 100 %	5 / 5 100 %	5 / 5 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002529

CHRONIC DISEASE – DIABETES

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? BOP

Item # Measure

1. Was blood sugar measured and recorded on intake?
2. Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3. Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4. Were lipids measured within one year?
5. Was patient followed at least every 90 days with appropriate vital signs?
6. Was aspirin prescribed, as clinically indicated?*
7. Was degree of control (goal GgbA1C<8.0) documented?
8. Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NA	NA	NA	NA
2		YES	YES	YES	YES	YES	NA	YES	YES
3		YES	YES	YES	YES	YES	NA	YES	YES
4		YES	YES	YES	NA	YES	NA	YES	YES
5		YES	YES	YES	NA	YES	NA	YES	YES
6		YES	NA	NA	NA	NA	NA	NA	NA
7		YES	YES	NA	NA	NA	NA	NA	NA
8		YES	YES	NA	NA	NA	NA	NA	NA
9		YES	YES	YES	NA	NA	NA	NA	NA
10		YES	YES	NA	NA	NA	NA	NA	NA
	Total	2 / 2 100%	2 / 2 100%	2 / 2 100%	1 / 1 100%	1 / 1 100%	n / a Na%	1 / 1 100%	1 / 1 100%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? BOP

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within the past 3 months? Were lipids measured
4	within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated? *
7	Was degree of control (goal HgbA1C <8.0) documented?
8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	N/A	YES	YES	YES
2		YES	YES	YES	YES	N/A	YES	YES	YES
3		YES	YES	YES	YES	N/A	YES	YES	YES
4		YES	YES	YES	YES	YES	N/A	N/A	N/A
5		NA	YES	YES	YES	YES	N/A	N/A	N/A
6		YES	YES	YES	YES	YES	N/A	N/A	N/A
7		YES	YES	YES	N/A	YES	N/A	N/A	N/A
8		YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9		YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10		YES	YES	YES	YES	YES	N/A	N/A	N/A
	Total	3 /3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	N /A NA %	3 /3 100 %	3 / 3 100 %	3 / 3 100 %

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1 Was there a documented time urgency included on the order for specialty care or diagnostic services?
2 Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3 Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4 Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	General Surgery	YES	YES	N/A	YES
2		Oncology	YES	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Infectious Disease	YES	YES	N/A	YES
5		General Surgery	YES	YES	N/A	YES
6		Opthalmology	YES	YES	N/A	YES
7		Opthalmology	YES	YES	N/A	YES
8		Orthopedics	YES	YES	N/A	YES
9		Cardiology	YES	YES	N/A	YES
10		Orthopedics	YES	YES	N/A	YES
		Total	10 / 10 100%	10 / 10 100%	n / a NaN%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002532

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1 Was there a documented time urgency included on the order for specialty care or diagnostic services?
2 Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3 Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4 Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	YES	YES	N/A	YES
2		Other	YES	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Other	YES	YES	N/A	YES
5		Other	YES	YES	N/A	YES
6		Other	YES	YES	N/A	YES
7		Other	YES	YES	N/A	YES
8		Other	YES	YES	N/A	YES
9		Other	YES	YES	N/A	YES
10		Other	YES	YES	N/A	YES
		Total	10 / 10 100%	10 / 10 100%	0 / 0 N/A%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2008 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item #	Measure
1	Is there an outbound progress note?
2	*Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3	Is there discharge documentation from the hospital or ED in the chart?
4	Is there an inbound assessment?
5	Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Abd Pain	YES	NO	YES	YES	YES
2		Abd Pain	YES	NO	YES	YES	YES
3		Abd Pain	YES	NO	YES	YES	YES
4		Kidney Stone	YES	NO	YES	YES	YES
5		Abd Pain	YES	NO	YES	YES	YES
6		Chest Pain	YES	NO	YES	YES	YES
7		Abd Pain	YES	NO	YES	YES	YES
8		Chest Pain	YES	NO	YES	YES	YES
9		Foot Infection	YES	NO	YES	YES	YES
10		Chest Pain	YES	NO	YES	YES	YES
			10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002534

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Head Injury	YES	NO	YES	YES	YES
2		Eye Swelling	YES	NO	YES	YES	YES
3			YES	NO	YES	YES	YES
4			YES	NO	YES	YES	YES
5			YES	NO	YES	YES	YES
6			YES	NO	YES	YES	YES
7			NO	NO	NO	NO	YES
8			NO	NO	NO	NO	YES
9			NO	NO	NO	NO	YES
10			NO	NO	NO	NO	YES
			2 / 2 100 %	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %	2 / 2 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2008 J-E-12.

Revised May 2014

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002535

HEALTH ASSESSMENT

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	YES	NA	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	20 / 20 100 %	12 / 12 100 %	20 / 20 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 6/7/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?

2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?

3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?

4 Is there timely follow-up for significant findings of acute and chronic conditions?*

5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 6/7/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Detention Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	NA	YES	YES
	Total	20 / 20 100 %	20 / 20 100 %	7 / 7 100 %	20 / 20 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1. Initial screen complete within 12 hours of booking?
2. PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3. Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4. Is there timely follow-up for significant findings of acute and chronic conditions?*
5. Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	2 / 2 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP

Item #	Measure
1	How was HIV status identified? By laboratory, prior medical records or patient report?
2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4	Was antiretroviral treatment considered and documented?
5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Medical Record	YES	NA	YES	YES	YES
2		Medical Record	YES	NA	YES	YES	YES
3		Medical Record	YES	NA	NA	YES	YES
4		Medical Record	NA	NA	YES	YES	YES
5		Medical Record	YES	NA	YES	YES	YES
6		Medical Record	YES	YES	YES	YES	YES
7		Medical Record	YES	YES	YES	YES	YES
8		Medical Record	YES	YES	YES	YES	YES
9		Medical Record	YES	NA	YES	NA	YES
10		Medical Record	YES	YES	NA	YES	YES
	Total		/ NaN%	/ NaN%	/ NaN%	/ NaN%	/ NaN%

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002541

CHRONIC DISEASE – HIV

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV BOP

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	NONE	Medical Record	YES	NA	YES	YES	YES
2		Medical Record	YES	NA	YES	YES	YES
3		Medical Record	NA	NA	YES	YES	YES
4		Medical Record	YES	NA	YES	YES	YES
5		Medical Record	NA	NA	YES	YES	YES
6		Medical Record	YES	NA	YES	YES	YES
7		Medical Record	YES	NA	YES	YES	YES
8		Medical Record	YES	NA	YES	YES	YES
9		Medical Record	YES	NA	YES	YES	YES
10		Medical Record	YES	NA	YES	YES	YES
	Total		/ N/A %	/ N/A %	/ N/A %	/ N/A %	/ N/A %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002542

CHRONIC DISEASE – HYPERTENSION

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? BOP

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	N/A	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	N/A	YES
6		YES	YES	N/A	YES
7		YES	YES	YES	YES
8		YES	YES	N/A	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	YES
	Total	9 / 9 100 %	9 / 9 100 %	4 / 4 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002543

CHRONIC DISEASE – HYPERTENSION

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? BOP

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	N/A	N/A
2		YES	YES	N/A	YES
3		YES	YES	N/A	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	N/A	YES
7		YES	YES	YES	YES
8		YES	YES	N/A	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	6 / 6 100 %	6 / 6 100 %	2 / 2 100 %	5 / 5 100 %

KEY: NA= not applicable

NCCHC Guideline for Disease Management, Hypertension, (April 2013). http://www.ncchc.org/guidelines; ACA 2004 4-ALDF-4C-19.

AMERICAN OVERSIGHT

ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (Follow Up to FMC Site Visit: 5/14/2019 to 5/16/2019

Facility Name: CIBOLA COUNTY CORRECTIONAL CENTER	**Address (Full):** 2000 Cibola Loop, P.O. Box 3540	
Date FMC Initiated Request for UCAP: December 2. 2019	**City:** Milan	**County:** Cibola
Complete and Return to IHSC FMC No Later Than: December 6, 2019	**State:** New Mexico	**Zip Code:** 87021
Name of Facility Staff Assigned to Develop / Oversee Corrective Action Plan: (b)(6); (b)(7)(C) Acting Health Service Administrator		
Date CAP Submitted by Facility: **12/12/2019**		
IHSC Approver – Print Name (First, Last): (b)(6); (b)(7)(C)	**Title of IHSC Approver:** **Western Regional Field Medical Coordinator**	
Date CAP Approved by IHSC: **02/25/2020**		
Signature and Date IHSC Closed Out CAP: (b)(6); (b)(7)(C)	**March 25, 2020**	

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Reviews) Cibola County Correctional Center (El Paso AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
PBNDS 2011 Standard: 4.3 Medical Care, II Expected Outcomes, 4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up **Findings:** Through detainee interviews and chart reviews, CCCC medical is not providing timely follow-up when requested through the sick call process.	With CoreCivic becoming the health care provider at Cibola as of 9/14/2019, CoreCivic Policy 13-80 Sick Call: Requests are to be triaged within 24 hours and inmate/resident patient seen by Qualified Healthcare Professional at sick call within next 24 hours (a total of 72 hours on weekend) unless emergency exist. Emergent issues are to be seen	9/14/2019	12/12/2019 FMC Site Visit found to be compliant per PBNDS 2011 standards.

AMERICAN OVERSIGHT

	immediately following triage and documented on 13-80A3 Sick Call Request Face- to face encounter available in English or Spanish.		
PBNDS 2011 Standard: 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements. (b)(7)(E)	CoreCivic removed the medical subcontractor Wellpath and will be providing sufficient staff to appropriate health care.	09/14/2019	12/12/2019 Per DEC 2019 site visit report, staffing was found sufficient per CoreCivic staffing plan.

AMERICAN OVERSIGHT

LABORATORY TESTING

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002548

LABORATORY TESTING

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NO
2		YES	YES	YES	YES	NO
3		YES	YES	YES	YES	NO
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	NO
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	NO
9		YES	YES	YES	YES	NO
10		YES	YES	YES	YES	NO
	Total	10 / 0 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	3 / 10 30 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002549

MEDICAL RECORDKEEPING PRACTICES

DATE 01/024/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	NA	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	NA	NA	Compliant	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	Compliant	NA	Compliant	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/024/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	NA	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	Compliant	Compliant	Compliant
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	Compliant	Compliant	Compliant
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 6/7/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
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MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	NA	NA	NA	NA	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 6/7/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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Flowsheets	NA	NA	Compliant	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	Compliant
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/1242017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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	Alien #	Alien#	Alien #	Alien#	Alien #
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Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
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Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	NA	NA
Flowsheets	Compliant	Compliant	Compliant	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	Compliant	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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Type of medical record: ✔ Paper ☐ Electronic ☐ Both Name of Electronic Health Record:

	Alien # (b)(6); (b)(7)(C)	Alien#	Alien #	Alien#	Alien #
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
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Flowsheets	NA	Compliant	Compliant	NA	NA
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	Compliant	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	NA	NA	NA	NA	NA
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	NA	NA	NA	NA	NA
Integrated health information with EHR, where applicable[9]	NA	NA	NA	NA	NA

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? NO
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 1%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 60
5 OTCs provided by medical, commissary or both? Medical

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	2	NA	NA
2		1	NA	NA
3		2	NA	NA
4		2	NA	NA
5		2	NA	NA
6		0	NA	NA
7		0	NA	NA
8		1	NA	NA
9		0	NA	NA
10		0	NA	NA
	Total		n /a NaN%	n /a NaN%

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002556

MEDICATION ADMINISTRATION PRACTICES

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 10%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 10%
5 OTCs provided by medical, commissary or both? Medical

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		0	NA	NA
4		0	NA	NA
5		0	NA	NA
6		0	NA	NA
7		0	NA	NA
8		0	NA	NA
9		0	NA	NA
10		0	NA	NA
	Total		0 /0 N/A%	0 /0 N/A%

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 01/09/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Processing Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # **Measure**

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		NA
	Total	9 / 9 100 %

KEY: NA = Not Applicable

Revised September 2016

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002560

MENTAL HEALTH TREATMENT PLANNING

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item # Measure

1 Is a clinical assessment, treatment, and follow-up plan documented?

2 Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	9 / 9 100 %	9 / 9 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002561

INTAKE EVALUATION: PREGNANT WOMEN

DATE_____ REVIEWER_____

FACILITY REVIEWED_____

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1		NA	NA	NA	NA	NO	NO
2		NA	NA	NA	NA	NO	NO
3		NA	NA	NA	NA	NO	NO
4		NA	NA	NA	NA	NO	NO
5		NA	NA	NA	NA	NO	NO
6		NA	NA	NA	NA	NO	NO
7		NA	NA	NA	NA	NO	NO
8		NA	NA	NA	NA	NO	NO
9		NA	NA	NA	NA	NO	NO
10		NA	NA	NA	NA	NO	NO
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002562

INTAKE EVALUATION: PREGNANT WOMEN

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To determine compliance with detention standards and continuity and coordination of care.

Source: Current census of pregnant detainees.

Sample: 10 pregnant detainees.

Item #	Measure
1	Was a pregnancy test performed on females aged 10-54 during intake screening?
2	Was a pregnancy test performed prior to x-ray or before initiation of any medications?
3	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?
4	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?
5	Was the pregnant patient screened for HIV, STI and viral hepatitis?
6	Were prenatal vitamins prescribed?

	A #	1	2	3	4	5	6
1	NO FEMALES	NA	NA	NA	NO	NO	NO
2	AT	NA	NA	NA	NO	NO	NO
3	THIS FACILITY	NA	NA	NA	NO	NO	NO
4		NA	NA	NA	NO	NO	NO
5		NA	NA	NA	NO	NO	NO
6		NA	NA	NA	NO	NO	NO
7		NA	NA	NA	NO	NO	NO
8		NA	NA	NA	NO	NO	NO
9		NA	NA	NA	NO	NO	NO
10		NA	NA	NA	NO	NO	NO
	Total	/ %	/ %	/ %	/ %	/ %	/ %

NCCHC 2008 J-G-07; ACA 2004 4-ALDF-4C-13.

AMERICAN OVERSIGHT

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Cibola County Correctional Center			
AOR:*	ELP			
Address:	2000 Cibola Loop			
City:	New Mexico		**County:**	Cibola
State:*	NM	**Zip:**		
Inspection Information				
Start Date:*	2/4/2020			
End Date:*	2/6/2020			
Organization:*		IHSC		
# Detainees at Time of Visit:		48		
Total Facility Population at Time of Visit:		618		
Facility Capacity:		1100		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	2/14/2020
Signature:	2/14/2020 X (b)(6); (b)(7)(C) Signed by: People			

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DHS-ICE-20-0618-A-002564

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	100%	
CG	Complaints and Grievance	0	*Total Number
CM	Continuity of Medications	71%	
DC	Dental Care	100%	
DM	Diabetes	92%	
DSA	Diagnostic Services and Specialty Care Access	93%	
EED	Evaluation of Care Prior to Emergency Department		
HA	Health Assessment	85%	
HIV	Human Immunodeficiency Virus	90%	
HTN	Hypertension	100%	
LT	Laboratory Testing	80%	
MR	Medical Recordkeeping	99%	
MAR	Medication Administration Records	50%	
MHS	Mental Health Screen	90%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder		
SS	Suicide Screening		
TD	Treatment of Disability		
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Administrative Assistant						
Medial Translators						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		1							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.								
Source:	Chronic disease registry or MARs (Medical Administrative Record).								
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.								
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm								
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/4/2020				
Facility (f)									
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y				
fASM-1b:	If yes, what is the guideline?			BOP					
Clinical (c)									
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
cASM-2	Was a peak flow completed at the initial physical exam?								
cASM-3	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.								
Total Applicable:		1	1	1	1				
Total Met:		1	1	1	1				
% Compliance:	100%	100%	100%	100%	100%				
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**				
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes				
2		Select	Select	Select	Select				
3		Select	Select	Select	Select				
4		Select	Select	Select	Select				
5		Select	Select	Select	Select				
6		Select	Select	Select	Select				
7		Select	Select	Select	Select				
8		Select	Select	Select	Select				
9		Select	Select	Select	Select				
10		Select	Select	Select	Select				

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 2/4/2020

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP
	Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?	
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)	
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?	
cDM-4	Were lipids measured within one year?	
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?	
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.	
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?	
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?	

Total Applicable:		3	3	3	2	2	1	3	2
Total Met:		3	3	2	2	2	1	2	2
% Compliance:	92%	100%	100%	67%	100%	100%	100%	67%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	No	N/A - LOS	N/A - LOS	N/A - NLOS	No	N/A - LOS
3		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
4		Select	Select	Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select	Select	Select

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6		Select	Select	Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	Select	Select	

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HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	2						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	HIV medications are not being started in a timely manner. The faciltiy took 9 days from the ID specialist's order to start the HIV medication. (b)(6); (b)(7)(C)						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	2/4/2020			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						

Total Applicable:			2	2	2	2	2
Total Met:			2	1	2	2	2
% Compliance:	90%		100%	50%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	Yes	Yes	Yes	Yes	
2		Patient Interview	Yes	No	Yes	Yes	Yes	
3		Select	Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

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HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	2							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/4/2020			
Facility (f)								
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y			
fHTN-1b:	If yes, what is the guideline?		BOP					
Clinical (c)								
cHTN-1	Was a blood pressure reading noted at intake?							
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Total Applicable:		2	1	1	1			
Total Met:		2	1	1	1			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
1	(b)(6); (b)(7)(C)	Y	N/A - LOS	N/A - LOS	N/A - LOS			
2		Y	Yes	Yes	Yes			
3		Select	Select	Select	Select			
4		Select	Select	Select	Select			
5		Select	Select	Select	Select			
6		Select	Select	Select	Select			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	Facility did not had any seizure patients to be reviewed					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	2/5/2020		
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		0	0	0	0	0
Total Met:		0	0	0	0	0
% Compliance:						

Patient(s)	A# (numbers only)	cSZ-1	cSZ-2	cSZ-3	cSZ-4	cSZ-5
1		Select	Select	Select	Select	Select
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	2/4/2020

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		4	3
Total Met:		3	2
% Compliance:	71%	75%	67%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(7)(E)	Yes	Yes
2		Yes	N/A - LOS
3		Yes	Yes
4		No	No
5		Select	Select
6		Select	Select
7		Select	Select
8		Select	Select
9		Select	Select
10		Select	Select

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DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/4/2020			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	0	0			
Total Met:		10	10	0	0			
% Compliance:	100%	100%	100%					
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	N/A - NLOS			
2		Y	Yes	N/A - NLOS	N/A - NLOS			
3		Y	Yes	N/A - NLOS	N/A - NLOS			
4		Y	Yes	N/A - NLOS	N/A - NLOS			
5		Y	Yes	N/A - NLOS	N/A - NLOS			
6		Y	Yes	N/A - NLOS	N/A - NLOS			
7		Y	Yes	N/A - NLOS	N/A - NLOS			
8		Y	Yes	N/A - NLOS	N/A - NLOS			
9		Y	Yes	N/A - NLOS	N/A - NLOS			
10		Y	Yes	N/A - NLOS	N/A - NLOS			

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	5					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:	#3- patient has not been seen after outside appointment, no records received or reviewed as of yet. Records where requested on 2/6/2020.					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	2/6/2020		
Clinical (c)						
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?					
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?					
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?					
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?					
Total Applicable:			5	5	0	5
Total Met:			5	5	0	4
% Compliance:	93%		100%	100%		80%
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**
1	(b)(6); (b)(7)(C)	Other	Yes	Yes	N/A - NLOS	Yes
2		Other	Yes	Yes	N/A - NLOS	Yes
3		Other	Yes	Yes	N/A - NLOS	No
4		Infectious Disease	Yes	Yes	N/A - NLOS	Yes
5		Other	Yes	Yes	N/A - NLOS	Yes
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	No ER referrals for time period reviewed.							
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**	2/5/2020		
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			0	0	0	0	0	
Total Met:			0	0	0	0	0	
% Compliance:								
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1			Select	Select	Select	Select	Select	
2			Select	Select	Select	Select	Select	
3			Select	Select	Select	Select	Select	
4			Select	Select	Select	Select	Select	
5			Select	Select	Select	Select	Select	
6			Select	Select	Select	Select	Select	
7			Select	Select	Select	Select	Select	
8			Select	Select	Select	Select	Select	
9			Select	Select	Select	Select	Select	
10			Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	No complaints or grievances for the time reviewed.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/6/2020		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			0			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			0			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	0	0	0	0	0	0	0
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1		Select	Select	Select	Select	Select	Select
2		Select	Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

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HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	Over 14 day PE: #16, 17, 18, 19 Chronics with PE over 2 business days: 2, 3, 8 (of 10 chronic charts reviewed)					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/5/2020	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	18	9	11	16
Total Met:		16	16	9	11	9
% Compliance:	85%	80%	89%	100%	100%	56%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		No	Yes	Yes	Yes	No
3		Yes	Yes	Yes	Yes	No
4		Yes	No	N/A	Yes	Yes
5		Yes	No	N/A	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		No	Yes	Yes	Yes	No
9		Yes	Yes	Yes	N/A - LOS	N/A - LOS
10		No	N/A	N/A	N/A - LOS	N/A - LOS
11		No	N/A	N/A	N/A - LOS	N/A - LOS
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	N/A	Yes	Yes
14		Yes	Yes	N/A	N/A - NLOS	N/A - NLOS
15		Yes	Yes	N/A	Yes	Yes
16		Yes	Yes	Yes	N/A - NLOS	No
17		Yes	Yes	N/A	N/A - NLOS	No
18		Yes	Yes	N/A	N/A - NLOS	No
19		Yes	Yes	N/A	N/A - NLOS	No
20		Yes	Yes	N/A	N/A - NLOS	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		4					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	Orders in electronic health records are not appropriately inputted, causing delayed or missed orders. Providers are unfamiliar with inputting stat orders in the EMR. (all A#s).						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/5/2020		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		4	4	4	2	2	
Total Met:		0	4	4	2	2	
% Compliance:	80%	0%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	No	Yes	Yes	N/A - LOS	N/A - LOS	
2		No	Yes	Yes	Yes	Yes	
3		No	Yes	Yes	N/A - LOS	N/A - LOS	
4		No	Yes	Yes	Yes	Yes	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)				**Date Reviewed:**	2/6/2020			

Facility (f)		
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?	Y
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?	30
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?	0
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.	1
fMAR-5:	OTCs provided by medical, commissary or both?	Both

Clinical (c)	
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

Total Applicable:			2	2					
Total Met:			1	1					
% Compliance:	50%		50%	50%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	1	Yes	Yes					
2		2	N/A - NLOS	N/A - NLOS					
3		1	N/A - NLOS	N/A - NLOS					
4		0	N/A - NLOS	N/A - NLOS					
5		1	N/A - NLOS	N/A - NLOS					
6		0	N/A - NLOS	N/A - NLOS					
7		0	N/A - NLOS	N/A - NLOS					
8		6	No	No					
9		0	N/A - NLOS	N/A - NLOS					
10		1	N/A - NLOS	N/A - NLOS					

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MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	Consents for psychotropic not completed on intake. 2, 4 Results of specialty consultation not in chart. 10
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 2/6/2020

Facility (f)		
fMR-1:	Type of Medical Records?	Electronic
fMR-2:	Name of Electronic Health Record?	All Script

Total Applicable:		10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Total Met:		10	10	10	10	10	10	10	10	8	10	9	10	10	10	10	10	10	10	10	10	10	10
% Compliance:	99%	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial Compliance	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial Compliance	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Non-Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

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MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:	#2 mental health seen over 72 hrs.							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	2/5/2020				
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Total Applicable:		10						
Total Met:		9						
% Compliance:	90%	90%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		No						
3		Yes						
4		Yes						
5		Yes						
6		Yes						
7		Yes						
8		Yes						
9		Yes						
10		Yes						

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/5/2020				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	9						
Total Met:		10	9						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	N/A - LOS						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	No pregnant detainees at facility.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/4/2020		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			N/A			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	No suicide cases to review from last visit.					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	2/4/2020		

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	0
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			0	0	0	0
Total Met:			0	0	0	0
% Compliance:						

Patient(s)	A# (numbers only)	cSS-1	cSS-2	cSS-3	cSS-4	cSS-5
1		Select	Select	Select	Select	Select
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	No detainees with disabilities during period reveiwed.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	2/4/2020		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		0	0	0	0		
Total Met:		0	0	0	0		
% Compliance:							
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1		Select	Select	Select	Select		
2		Select	Select	Select	Select		
3		Select	Select	Select	Select		
4		Select	Select	Select	Select		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	2/6/2020	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	3	3	
Total Met:			10	10	10	3	3	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Constipation	Yes	Yes	Yes	Yes	Yes	
2		Upper Respiratory	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
3		Not feeling well	Yes	Yes	Yes	Yes	Yes	
4		Hand pain	Yes	Yes	Yes	Yes	Yes	
5		Upper Respiratory	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
6		Upper Respiratory	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
7		Upper Respiratory	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
8		Head Ache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
9		Abdominal Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
10		Upper Respiratory	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	

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SUICIDE SCREENING

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 2

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		YES	YES	Constant (1:1)	YES	NO
9		YES	YES	Constant (1:1)	YES	NO
10		YES	YES	Constant (1:1)	YES	NO
	Total	10 /10 100 %	10 /10 100 %		10 /10 100 %	10 /10 100 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 2

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ☑ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ☑ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		NO	NO	At least q 15 min	NO	NO
9		NO	NO	At least q 15 min	NO	NO
10		NO	NO	At least q 15 min	NO	NO
	Total	2 / 2 100 %	2 / 2 100 %	/ %	2 / 2 100 %	2 / 2 100 %

KEY: NA= not applicable

NCCHC 2008 J-G-05 and Appendix C; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 01/24/2018 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Cibola County Correctional Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	NONE	YES	YES	NA	NA
2		YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA = not applicable

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 01/24/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Cibola County Correctional Center

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? N/A

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	NONE	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	YES	NA
6		YES	YES	YES	NA
7		YES	YES	YES	NA
8		YES	YES	YES	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	/ %	/ %	/ %	/ %

KEY: NA = not applicable

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Fever	YES	YES	YES	YES	YES
2		Cold Symptoms	YES	YES	YES	YES	YES
3		Rectal Bleeding	YES	YES	YES	YES	YES
4		Abdominal Pain	YES	YES	YES	YES	YES
5		Blurred vision	YES	YES	YES	NA	NA
6		Rash to lower back	YES	YES	YES	YES	YES
7		Headache	YES	YES	YES	YES	YES
8		Anxiety	YES	YES	YES	YES	YES
9		Cold symptoms	YES	YES	YES	NA	NA
10		Hemmoroids	YES	YES	YES	YES	YES
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002598

URGENT CARE (SICK CALL)

DATE 01/10/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Otero County Process Center

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Toothache	YES	YES	YES	YES	YES
2		Dandruff	YES	YES	YES	N/A	N/A
3		Request MH	YES	YES	YES	YES	YES
4		Abd Discomfort	YES	YES	YES	YES	YES
5		HA	YES	YES	YES	N/A	N/A
6		HA	YES	YES	YES	N/A	N/A
7		Cold Symptoms	YES	YES	YES	N/A	N/A
8		Cough	YES	YES	YES	N/A	N/A
9		Cold Symptoms	YES	YES	YES	N/A	N/A
10		Toothache	YES	YES	YES	YES	YES
		Total	10 / 10 100%	10 / 10 100%	10 / 10 100%	4 / 4 100%	4 / 4 100%

KEY: NA= not applicable

NCCHC 2008 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? BOP

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		NO	YES	NA	YES
3		YES	YES	YES	YES
4		NA	YES	NA	YES
5		YES	YES	YES	YES
6		NA	YES	NA	YES
7		NA	YES	NA	YES
8		NA	YES	NA	YES
9		NA	YES	NA	YES
10		NA	YES	NA	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? BOP

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		NA	YES	NA	NA
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correction Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? BOP

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	NA	YES	YES	YES
3		YES	NA	NA	YES	YES
4		YES	NA	NA	YES	YES
5		YES	NA	NA	YES	YES
6		YES	NA	NA	YES	YES
7		YES	NA	NA	YES	YES
8		YES	NA	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	NO	YES	YES	YES
	Total	10 / 10 100 %	1 / 3 33.3%	5 / 5 100 %	10 /10 100 %	10 / 10 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002602

CHRONIC DISEASE – SEIZURE DISORDER

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? BOP

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	NA	NA	NA	YES
4		YES	NA	YES	YES	YES
5		YES	NA	NA	NA	YES
6		YES	NA	YES	YES	YES
7		YES	NA	NA	YES	YES
8		YES	NA	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002603

ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (FMC Site Visit Follow-up JAN 2017)

Facility Name	***Cibola County Correctional Center***
Address (Street and Name)	**2000 Cibola Loop, P.O. Box 3540**
City, State and Zip Code	**Milan, New Mexico 87021**
County	**Cibola**
Date[s] of FMC Follow-up	***January 24, 2017 to January 27, 2017***
Complete and Return to ICE HQ No Later Than:	**July 21, 2017**

Facility Corrective Action Plan Assigned to	***FIELD OFFICE***
Date of Final Submission:	

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Reviews) Cibola (El Paso AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
Forms requiring detainee signatures did not have an area for documentation of the use or non-use of a translator. (Patient speaks English, Provider fluent in patient's language, or translator used with translator name/number and language). STANDARD - PBNDS Medical Care 4.3 E. Facilities shall provide appropriate interpretation and language services for LEP (Limited English Proficiency) detainees...	(b)(5)	On January 26, 2017, the medical records staff will begin adding a sticker to all medical forms which require a detainee's signature the following: Detainee Speaks English Y or N; Staff Speaks Detainee's Language: Y or N; Language Spoken:_____ ___Did you use interpreter or language line? Name/Number:_____.	01/25/17: Medical records staff added stickers/verbiage to all forms requiring a detainee signature. Medical records will pull 10 charts per month and audit for stickers and report results to the AHSA

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002605

Scopes of practice for licensed non-independent providers were not documented. STANDARD - PBNDS Medical Care 4.3 I. All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review.	(b)(5)	*AHSA is working to develop a scope of practice for all NON-LIP providers - specifically LPN's and RN's. Once completed all LPN's and RN's will have their competency in their scope of practice evaluated by the DON and documented in their personnel file. Expected time to completion 3/1/17.*	2/20/17: All medical staff requiring Scopes of Practice now have one filed in their personnel file. The DON has conducted core competencies for all staff. Competencies will be evaluated annually. Current and new staff are placed on a spreadsheet for tracking of competencies.
Medical staff is not familiar with the location of medications or equipment in the crash cart or emergency response bag. (QUALITY OF CARE)		Beginning the week of January 30, 2017, the DON will conduct man down drills and other emergency training with all nursing staff to better prepare them for emergency responses. Drills and training will be documented and the DON will evaluate the competency of nursing staff. Training is on-going and will be conducted on all shifts.	01/30/2017

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Medical crash cart is secured with a metal lock and the majority the medical staff do not have access to open the lock (QUALITY OF CARE)	(b)(5)	(b)(7)(E)	1/30/2017
Medical staff N-95 OSHA medical evaluation and fit testing not documented. (QUALITY OF CARE)		Currently working with CoreCivic Safety Manager to accomplish N-95 testing for all staff. If not accomplished through CoreCivic within 30 days, HSA will gather the necessary testing equipment, have medical staff complete health information questions relevant to wearing a mask, and have the DON administer the fit-test to all medical staff. Projected completion 2/28/17. Training is on-going and will be conducted on all	3/1/2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002607

		shifts.	
No record of staff varicella immunity status which may place them at risk due to the higher than normal incidents of varicella with ICE detainees. (QUALITY OF CARE)	(b)(5)	Beginning 1/30/17, the DON will have all medical staff complete a questionnaire regarding their immunity to varicella. The documentation will be filed in the employees CCS medical file.	1/30/2017
Vital signs are not being completed on all clinical visits; specifically, mental health and dental encounters. (QUALITY OF CARE)		On January 25, 2017, informed (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Mental Health, of the requirement for vital signs on all clinical visits. Nurses will do vitals for all providers to include dental and mental health appointments - dental can also do their own vitals if time permits. Train Mental Health Staff and Dental Assistant in obtaining vital signs. Beginning 2/6/17 the AHSA will review 10 files from Mental Health clinic visits conducted after 1/26/17 and review for vital signs. Beginning 2/6/17 the DON will review 10 charts every other	01/26/17: Effective 1/26/17 Mental health patients are staged in medical waiting area and nursing staff conducts vitals and records for mental health provider. Dental staff conducts vitals in dental and records on their paperwork.

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		week from Dental Clinic Visits conducted after 1/26/17 and review for vital signs. Bi-weekly audits will continue until 100% compliance is achieved.	
Review of intake transfer summaries is not documented. (QUALITY OF CARE)	(b)(5)	On January 30, 2017, the DON will conduct a training session with all Nursing staff on how to properly document the review of the transfer summary. A training log will be maintained. The QA nurse will add the review of the transfer summary to the list of file areas to audit post intake.	1/30/2017
Lab results are not being reviewed with the patients (QUALITY OF CARE)		A form has been generated to provide documentation of compliance. Beginning 1/30/17 Medical Records staff will generate a list of Detainees who have previously been scheduled for labs. These detainees will be scheduled with the provider- the provider will review all labs with the detainee and document the review on the acknowledgement form. The acknowledgement will be maintained in the Laboratory section of the detainee	3/1/2017

AMERICAN OVERSIGHT

		medical file. Detainees on Chronic Clinics will have their labs reviewed with the provider at the next chronic clinic and the provider will note this on the lab results when the labs are signed off by the provider. Detainees not on a chronic clinic who have labs drawn, will be scheduled with provider for follow-up of labs. The detainee will sign an acknowledgement that his labs have been reviewed with him and the acknowledgement filed in the detainee's medical record. Beginning the week of 2/6/17, the ID Nurse will pull 10 charts per week of detainees who have had labs drawn and audit for compliance. Currently Cibola uses IHSC Site Visit Tools for CQI.	
Insulin dependent diabetics are not required to have lower bunks (QUALITY OF CARE)	(b)(5)	On January 27, 2017 providers will now issue lower bunks to all IDDM and seizure patients. QA nurse will review charts of all IDDM and seizure CC's to insure detainee has a lower bunk designation. The QA	1/27/2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002610

		nurse will add a Lower Bunk column to the Chronic Clinic spreadsheet and insure all IDDM and Seizure CC patients have lower bunk assignment.	

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DHS-ICE-20-0618-A-002611

Reset Form | Email Form | Print Form

DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
12/10/2019	05/14/2019	Cibola County Correctional Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
137	137	0	26	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
1	0	1	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)	Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)
Address: 2000 Cibola Loop Milan, NM 87021	Address: 2000 Cibola Loop Milan, NM 87021

Medical Care

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☒ >3 Standards

Description of deficiencies:

• PBNDS 2011 4.3, V, B - The HSA is a physician or health care professional and shall be identified to detainees.
FINDINGS: The newly hired HSA is not a licensed health care professional.

• PBNDS 2011 4.3, IV, M – Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
FINDINGS: Comprehensive health assessments are not being completed within 14 days of arrival to Cibola. 16 of 20 (80%) had a completed health assessments within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days. A#s for non-compliant charts: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, V, C, 2 - …screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines
FINDINGS: For a two-month period, detainees only received TB symptom screening while at the facility due to a national shortage of PPD. (Note: Chest x-ray or blood testing was not used as an option during the 2 month period.) 12 of 20 (60%) had a PPD placed during medical screen when applicable and read within 48-72. A#s for non-compliant charts: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, IV, O, 3 & 4 - Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary.

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FINDINGS: Seven of ten (70%) detainees referred for mental health evaluation were being evaluated by a mental health provider within 72 hours of the referral. A#s for non-compliant charts: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, V, O, 4 - The provider shall develop an overall treatment/management plan.
FINDINGS: Nine of ten (90%) had a treatment plan documented on detainees evaluated by mental health providers. A# for non-compliant chart: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, II, 22 - Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations.
Findings: Four out of seven (57%) nursing staff interviewed, medical staff are not receiving training in proper use of medical emergency equipment; e.g. equipment in emergency bags -- some nurses have never looked into the bag or know how to use oral airways or the manual pump.

• PBNDS 2011 4.3, II, 23 - Information about each detainee's health status shall be treated as confidential.
FINDINGS: Based on interviews with multiple detainees in three separate dorms, they stated that they place their sick call slips under the security door. Then the security staff deposit them in the medical box.

Findings from May 2019 Site Visit:

• 4.3 Medical Care, II Expected Outcomes, 4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up
Findings: Through detainee interviews and chart reviews, CCCC medical is not providing timely follow-up when requested through the sick call process.
CURRENT FINDINGS: Compliant

• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
Findings: There are 11 full time registered nurses, along with 5 as needed nurses doing each an average of 25 hours a week. This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in 136 hours of overtime.
CURRENT FINDINGS: Compliant

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
32	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
• PBNDS 2011 4.3, IV, J - Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.
FINDINGS: Seven of ten (70%) detainee identified as having chronic medical conditions had having their initial chronic care/health assessment completed in 2 working days by a medical provider. A#'s for non-compliant charts: (b)(6); (b)(7)(C)

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There have been no reported hunger strikes since medical management transition to CoreCivic. Review of facility hunger strike policy noted to follow PBNDS 2011 standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 1 suicide watch medical record since transition from WellPath to CoreCivic. Detainee was placed on 1:1 constant watch, 15 minute wellness checks noted in the medical charts. Review of medical staff training records had required suicide prevention and intervention documentation. The review of the security officer's suicide watch form by medical staff is not documented within the medical chart.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS 2011 standards.

Other Observations

Site Visit from 12/10/2019-12/13/2019. A total number of 100 medical records were reviewed during the site visit. There were a limited number of medical records available for review due to this site visit only reviewing the records since Corecivic began operating the medical department.

Facility Data:
IGSA operated by CoreCivic, with the medical department operated by CoreCivic as of Sept. 14, 2019.
Maximum facility population is 1100, and ICE maximum population is dependent on space available with USM and county prisoners. ICE contract has a guarantee minimum of 150 detainees; current ICE population is 137. The facility houses males in all 3 ICE custody classifications and transgenders in low and medium-low. The facility has a dedicated transgender dorm capable of housing up to 60 detainees who identify themselves as female. Current total custody population with ICE, USM, and county prisoners is at 779.

Type of Medical Records: AllScripts(EHR). Recently transitioned from paper-charts to EHR.

The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be used as suicide watch rooms.

--Reviewed (b)(7)(E) . Licensed personnel had current copies of licensure and up-to-date BLS certification.
--Documentation of required annual training is complete.
--Man-Down drills have been conducted and documented; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Facility has a full time pharmacy tech on staff. Medication refrigerator temperature logs checked and accurate. Quarterly pharmacist inspection and certification was documented.
--Medical housing, suicide watch, and segregation areas were observed. The review of the security officer's suicide watch form by medical staff is not documented
--Lab area refrigerator temperature log verified and accurate. CLIA license was current.
--Medical diets are available and ordered. The diets were renewed at least every 90 days when continuance needed.
--Transgender housing and care is based on the PBNDS 2011 standards; no issues were identified.

Deficiencies for Areas Evaluated

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PBNDS 2011:

• PBNDS 2011 4.3, V, B - The HSA is a physician or health care professional and shall be identified to detainees.
FINDINGS: The newly hired HSA is not a licensed health care professional.

• PBNDS 2011 4.3, IV, M - Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
FINDINGS: Comprehensive health assessments are not being completed within 14 days of arrival to Cibola.

• PBNDS 2011 4.3, V, C, 2 - …screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.
FINDINGS: For a two-month period, detainees only received TB symptom screening while at the facility due to a national shortage of PPD. (Note: Chest x-ray or blood testing was not used as an option during the 2 month period.)

• PBNDS 2011 4.3, IV, O, 3 & 4 - Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary.
FINDINGS: Detainees referred for mental health evaluation are not being evaluated by a mental health provider within 72 hours of the referral.

• PBNDS 2011 4.3, V, O, 4 - The provider shall develop an overall treatment/management plan.
FINDINGS: Treatment Plans were not documented on detainees evaluated by mental health providers.

• PBNDS 2011 4.3, II, 22 - Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations.
Findings: Medical staff are not receiving training in proper use of medical emergency equipment; e.g. equipment in emergency bags -- some nurses have never looked in to the bag or know how to use oral airways or the manual pump.

• PBNDS 2011 4.3, II, 23 - Information about each detainee's health status shall be treated as confidential.
FINDINGS: Security staff are handling sick call requests in order to deposit them in the medical box.

QMC Tool:

• Laboratory orders are not being completed as ordered by medical providers.
• Laboratory reports were not received back timely nor was there clinical acknowledgment of the findings.
• No time urgency is documented for specialty care or laboratory orders.
• No Special Needs Forms are completed for detainees that have medical equipment in general population
• SEG rounds medical documentation is not found in the patient medical chart. There is insufficient information on the security SEG monitoring form to clearly know patient medical/ mental health status.
• Refusals are not acquired for significant medications that are not administered (e.g. anticonvulsive, diabetic, hypertension, HIV, etc.).
• Detainees not taking medications consistently or missing 3 consecutive doses are not being referred to a medical provider.
• There are delays in providing HIV travel medications when detainees are released as mandated by immigration courts.
• Medical staff are not familiar with new CoreCivic medical policies and PBNDS 2011.
• Nursing is not documenting review of the security officer's suicide watch form.
• Detainees identified as having HIV are not seen by an infectious disease specialist within

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30 days of arrival.
• Detainees identified as having hypertension are not receiving base line laboratory tests as per CoreCivic chronic care guidelines.
• Diabetics did not have a baseline HgbA1C, degree of control documented nor a strategy to attain control.
• HIV patients did not have CD4 and viral loads drawn within 14 days of arrival or last 3 months.
• HIV patient did not have a CXR within 72 hours of arrival/identification; was only symptom screened.
• Vital signs on all medical encounters are not documented (Noted in sick call encounters).
• List of chronic care ICE detainees are not identified or separated from facility USM and County prisoners.
• No outbound or inbound progress note for detainee referred for emergency services.
• Hospital records noting the assessment, evaluation and treatment plan were not present in the medical record; only documents present were the patient discharge instructions.
• Post-hospital assessments do not reflect hospital findings and concurrence or justification for deviation from hospital recommendations.
• Mental health notes did not document assessment, treatment plan and follow-up.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to the QMC Inspection Worksheet.

Health Assessment

Refer to the QMC Inspection Worksheet.

Eight of 20 (40%) did not have a PPD placed during medical screen when applicable and read within 48-72; or, if PPD was positive, a chest x-ray was ordered and read. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

Four of 19 (21%) did not have timely follow up of a chronic condition. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

Four of 20 (20%) did not have a completed health assessments within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days. A#s: (b)(6); (b)(7)(C)

Urgent Care (Sick Call)

Refer to the QMC Inspection Worksheet.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to the QMC Inspection Worksheet.

Zero of one (0%) had notes for each outbound emergency encounter. (b)(6); (b)(7)(C)

Zero of one (0%) had discharge documentation from the hospital/Emergency Department(ED)in the chart. (b)(6); (b)(7)(C)

Zero of one (0%) had an inbound assessment. (b)(6); (b)(7)(C)

Zero of one (0%) had an assessment reflective of hospital finding or justification for deviations from hospital/ED recommendations upon return to the facility. (b)(6); (b)(7)(C)

NOTE: on 2/10/2020 - QMC tool revised for cEED-3 to reflect that patient did not have the actual ED notes in the medical record; only the patient education discharge information was available in the medical record.

Medication Administration Practices

Refer to the QMC Inspection Worksheet.

Five of ten (50%) of charts had three or more refusals. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

Six of seven (86%) of charts had three or more consecutive refusals that did not have required documentation that the prescribing clinician was notified of the consecutive refusals, as per facility policy. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

Six of seven (86%) that needed referral to a provider for 3 or more refusals did not have an appropriate response from the clinician. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Continuity of Medication

Refer to the QMC Inspection Worksheet.

One of four (25%) did not have medication ordered in less than 24 hours from time of completed intake screening. (b)(6); (b)(7)(C)
One of four (25%) did not have the first dose of medication administered in less than 24 hours. (b)(6); (b)(7)(C)

Mental Health Screen

Refer to the QMC Inspection Worksheet.

Three of 10 (30%) detainees referred for mental health evaluation were not being evaluated by a mental health provider within 72 hours of the referral. A#s: (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)

Medical Recordkeeping Practices

Refer to the QMC Inspection Worksheet.

Pregnant Women

N/A

Dental Care

Refer to the QMC Inspection Worksheet.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Acute Laboratory Testing

Refer to the QMC Inspection Worksheet.

One of three (33%) had blood drawn or test done within 1 business day of the ordered date. (b)(6); (b)(7)(C)

One of three (33%) had the report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs. (b)(6); (b)(7)(C)

One of three (33%) had clinical acknowledgment. (b)(6); (b)(7)(C)

Diagnostic Services and Specialty Care Access

Refer to the QMC Inspection Worksheet.

Mental Health Treatment Planning

Refer to the QMC Inspection Worksheet.

One of ten (10%) did not have a clinical assessment , treatment, and follow-up plan documented.

Treatment of Disability

Refer to the QMC Inspection Worksheet.

Complaints and Grievances

Refer to the QMC Inspection Worksheet.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to the QMC Inspection Worksheet.

Zero of one (0%) had baseline HgbA1c performance within 30 days.
Zero of one (0%) had documentation of degree of diabetes control.
Zero of one (0%) had a strategy to attain diabetes control when HgbA1C was above goal.
A#: (b)(6); (b)(7)(C)

Human Immunodeficiency Virus (HIV)

Refer to the QMC Inspection Worksheet.

One of five (20%) did not have a CD4+ and viral load completed within 14 days of arrival or within the last 3 months. A#: (b)(6); (b)(7)(C)
Four of five (80%) were not seen by an HIV/ID specialist within 30 days of identification.
A#s: (b)(6); (b)(7)(C)
One of five (20%) did not have a CXR completed within 72 hours of problem identification.
Patient only had a symptom screening done. A#: (b)(6); (b)(7)(C)

NOTE: 2/10/2020 QMC revision - Detainee (b)(6); (b)(7)(C) was added to the QMC tool; was inadvertently left off the original submission.

Hypertension

Refer to the QMC Inspection Worksheet.

One of three (33%) did not follow chronic disease guideline usage with included baseline laboratory. A# (b)(6); (b)(7)(C)

Asthma

Refer to the QMC Inspection Worksheet.

Seizure Disorder

Refer to the QMC Inspection Worksheet.

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Recommendations

(b)(5)

Facility Actions

HSA, warden, and several CoreCivic detention and medical representatives had a short meeting with FMC to discuss the facility findings.

Per CoreCivic Medical Director and (a)HSA, all deficiencies will be addressed promptly.

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Additional Comments

FMCs are not advised of issues from CoreCivic regarding medical serivces/issues. The FMCs are being notified by other entities of issues or concerns after the fact.
Facility is not tracking transgender detainees even after reeducation by FMCs. When information is requested, receipt is often delayed due to lack of tracking.

CRCL conducted a site visit to Cibola in August 2019; the final report is pending. However, notes from the close out report showed multiple issues concerning the medical care.

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 12/16/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 02/21/2020
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved: 02/21/2020
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 02/21/2020

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
07/31/2018	01/24/2018	Cibola County Correctional Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
260	233	0	27	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
3	3	3	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)	Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)
Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021	Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There were no PBNDS 2011 medical care deficiencies noted.

PREVIOUS SITE VISIT FINDINGS:

There were no PBNDS 2011 medical care deficiencies noted.

Chronic Care

Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.

Total number with chronic conditions:	Total number with unstable chronic conditions:
79	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. The facility uses BOP guidelines for chronic illnesses.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

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Description of deficiencies:

There have been no reported hunger strikes in the last 12 months. Review of facility hunger strike policy noted to follow PBNDS 2011 standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	26

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 10 suicide watch medical records since last site visit noted to comply with NCCHC and PBNDS standards. All were placed on 1:1 constant watch and every 15 minute documentation of patient observation was noted in the medical charts. Review of medical staff training records had required suicide prevention and intervention documentation.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS 2011 standards. The review on one medical recorded death in last 12 months showed the facility had treated the detainee with PBNDS 2011 standards. Detainee was identified as needing further medical attention during the intake medical screening, transported to the hospital, and succame to complications from their chronic medical conditions.

Other Observations

Site Visit from 7/31/2018 to 8/2/2018. A total of 126 medical records were reviewed during this site visit.

Facility Data:
IGSA operated by CoreCivic, with the medical department operated by Wellpath.
Maximum facility population is 1100, and ICE maximum population is dependent on space available with USM and county prisoners. ICE contract has a guarantee minimum of 150 detainees; current population 260. The facility houses males and transgenders in all 3 ICE custody classifications. The facility has a dedicated transgender dorm capable of housing up to 60 detainees who identify themselves as female.

Current Staffing:
(b)(7)(E)

Type of Medical Records: Paper charts. Wellpath is currently looking into companies providing software for Electronic Health Records (EHR).

The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be used as suicide watch rooms.

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--Reviewed (b)(7)(E) Licensed personnel had current copies of licensure and up-to-date BLS certification.
--Documentation of required annual training is complete.
--Man-Down drills have been conducted and documented; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Facility has a pharmacist on staff who completes quarterly reviews; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Lab area refrigerator temperature log verified and accurate.
--Over-the-Counter (OTC) medication is provided in medical and in commissary with the clinical director's and health authority's documented approval.
--Medical diets are available and ordered. The diets are renewed as needed.
--Transgender housing and care is based on the PBNDS 2011 standards; no issues were identified.

Deficiencies for Areas Evaluated

PBNDS 2011:

There were no PBNDS 2011 medical care deficiencies noted

Quality of Care:

--Detainees were not timely evaluated after submitting sick call requests or evaluated in a timely matter when referred to a medical providers from the sick call process.
--Blood Glucose levels were not documented on all diabetic detainees during the medical intake screening.
--Chest X-rays to rule out tuberculosis were not completed on all HIV detainees.
--Detainees refusing 3 consecutive prescribed medication or having consistently missed prescribed medication were not referred to the prescribing provider.
--Medication Administration Records (MARs) had several blank spaces for prescribed medications and no documentation regarding why medication was not administered/missed.
--Detainees with identified disabilities did not have documented assessments of needed assistance with activities of daily living (ADL) upon identification of disability.
--Detainees with asthma did not get a peak flow completed during the Chronic Care visits.
--Documentation of medical staff reviewing the suicide watch 1:1 documentation by security staff was not completed.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to the QMC Tools.

-There have been 20 suicide watches since the last site visit January 2018.

Health Assessment

Refer to the QMC Tools.

Urgent Care (Sick Call)

Refer to the QMC Tools.

Sick call requests were collected and triaged each day, and non-urgent requests were evaluated a given an appointment within 2 - 6 days, dependent on the medical complaint. The urgent care room had appropriate supplies and equipment needed for urgent/emergent care within the capabilities stated in facility policy (BLS).

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to the QMC Tools.

Medication Administration Practices

Refer to the QMC Tools.

The facility currently uses paper MARs. MARs had several blank spaces for prescribed medications and no documentation on why medication was not administered/missed. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee identification card. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

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Continuity of Medication

Refer to the QMC Tools.

Mental Health Screen

Refer to the QMC Tools.

Medical Recordkeeping Practices

Refer to the QMC Tools.

The facility uses paper charting and Wellpath is currently looking into companies providing software for Electronic Health Records.

Pregnant Women

ICE Females are not detained at the facility at this time.

Dental Care

Refer to the QMC Tools.

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Acute Laboratory Testing

Refer to the QMC Tools.

Diagnostic Services and Specialty Care Access

Refer to the QMC Tools.

Mental Health Treatment Planning

Refer to the QMC Tools.

Treatment of Disability

Refer to the QMC Tools.

All were non-applicable with providing ADL assistance due to all having ability to complete ADL without any assistance.

Complaints and Grievances

Refer to the QMC Tools.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to the QMC Tools.

Human Immunodeficiency Virus (HIV)

Refer to the QMC Tools.

Hypertension

Refer to the QMC Tools.

Asthma

Refer to the QMC Tools.

Seizure Disorder

Refer to the QMC Tools.

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Recommendations

(b)(5)

Facility Actions

HSA, warden, and facility ICE personnel had a short meeting with FMC to discuss the facility findings.

Per HSA Statement:

Facility CQI program will continue along with the use of IHSC site visit tools. The quality of care issues will be addressed.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 02/01/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 02/20/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 03/07/2019

Recommendations:
(b)(5)

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Cibola County Correctional Center			
AOR:*	ELP			
Address:	2000 Cibola Loop, P.O. Box 3540			
City:	Milan		**County:**	Cibola
State:*	NM	**Zip:**	87021	
Inspection Information				
Start Date:*	7/31/2018			
End Date:*	8/2/2018			
Organization:*		IHSC		
# Detainees at Time of Visit:		260		
Total Facility Population at Time of Visit:		916		
Facility Capacity:		1100		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	2/14/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by: (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	75%	
CG	Complaints and Grievance	7	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	100%	
DM	Diabetes	98%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	98%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	0%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	67%	
UC	Urgent Care (Sick Call)	96%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1						
Other 2						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		1						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		BOP					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		1	1	1	1			
Total Met:		1	1	0	1			
% Compliance:	75%	100%	100%	0%	100%			
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1	(b)(6); (b)(7)(C)	Yes	Yes	No	Yes			
2		Select	Select	Select	Select			
3		Select	Select	Select	Select			
4		Select	Select	Select	Select			
5		Select	Select	Select	Select			
6		Select	Select	Select	Select			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	9	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	Type Text Here	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 7/31/2018

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP
	Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?	
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)	
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?	
cDM-4	Were lipids measured within one year?	
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?	
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.	
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?	
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?	

Total Applicable:		8	9	6	6	3	0	6	6
Total Met:		7	9	6	6	3	0	6	6
% Compliance:	98%	88%	100%	100%	100%	100%		100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS
2		Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS
3		No	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes
4		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS
5		Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
9		N/A	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes	
10		Select	Select	Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	7/31/2018			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			10	8	8	8	10
Total Met:			10	8	8	8	9
% Compliance:	98%		100%	100%	100%	100%	90%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Medical Record	Yes	Yes	Yes	Yes	Yes	
2		Medical Record	Yes	Yes	Yes	Yes	Yes	
3		Medical Record	Yes	Yes	Yes	Yes	Yes	
4		Medical Record	Yes	Yes	Yes	Yes	Yes	
5		Medical Record	Yes	N/A - LOS	N/A - LOS	N/A - LOS	Yes	
6		Medical Record	Yes	Yes	Yes	Yes	No	
7		Medical Record	Yes	Yes	Yes	Yes	Yes	
8		Medical Record	Yes	Yes	Yes	Yes	Yes	
9		Medical Record	Yes	N/A - LOS	N/A - LOS	N/A - LOS	Yes	
10		Medical Record	Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	5	10	
Total Met:		10	10	5	10	
% Compliance:	100%	100%	100%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes
2		Y	Yes	Yes	Yes
3		Y	Yes	Yes	Yes
4		Y	Yes	Yes	Yes
5		Y	Yes	N/A - NLOS	Yes
6		Y	Yes	Yes	Yes
7		Y	Yes	N/A - NLOS	Yes
8		Y	Yes	N/A - NLOS	Yes
9		Y	Yes	N/A - NLOS	Yes
10		Y	Yes	N/A - NLOS	Yes

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		4				
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					

Total Applicable:		4	3	1	4	4
Total Met:		4	3	1	4	4
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	N/A - LOS	N/A - LOS	Yes	Yes
3		Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	Yes	N/A - NLOS	Yes	Yes
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	7/31/2018

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	10
Total Met:		10	10
% Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

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DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		8						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:	Type Text Here							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		8	8	8	5			
Total Met:		8	8	8	5			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	N/A - NLOS			
5		Y	Yes	Yes	N/A - NLOS			
6		Y	Yes	Yes	N/A - NLOS			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018	

Clinical (c)	
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

Total Applicable:			10	10	0	10
Total Met:			10	10	0	10
% Compliance:	100%		100%	100%		100%
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**
1	(b)(6); (b)(7)(C)	Orthopedics	Yes	Yes	N/A - NLOS	Yes
2		Other	Yes	Yes	N/A - NLOS	Yes
3		Infectious Disease	Yes	Yes	N/A - NLOS	Yes
4		Infectious Disease	Yes	Yes	N/A - NLOS	Yes
5		Infectious Disease	Yes	Yes	N/A - NLOS	Yes
6		Other	Yes	Yes	N/A - NLOS	Yes
7		Gastroenterology	Yes	Yes	N/A - NLOS	Yes
8		Opthalmology	Yes	Yes	N/A - NLOS	Yes
9		Opthalmology	Yes	Yes	N/A - LOS	Yes
10		Other	Yes	Yes	N/A - NLOS	Yes

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	7/31/2018	
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Abdominal Pain	Yes	No	Yes	Yes	Yes	
2		Abdominal Pain	Yes	No	Yes	Yes	Yes	
3		Fever	Yes	No	Yes	Yes	Yes	
4		Eye Injury	Yes	No	Yes	Yes	Yes	
5		Should Injury	Yes	No	Yes	Yes	Yes	
6		Abdominal Pain	Yes	No	Yes	Yes	Yes	
7		Cellulitis	Yes	No	Yes	Yes	Yes	
8		Abdominal Pain	Yes	No	Yes	Yes	Yes	
9		Urinary	Yes	No	Yes	Yes	Yes	
10		Abdominal/Chest Pain	Yes	No	Yes	Yes	Yes	

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	7						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	(b)(6); (b)(7)(C) wanting to see dental; sick call addresed in 72hrs (b)(6); (b)(7)(C) Requesting anxiety/bipolar meds. Arrived with no medicaitons or transfer summary; Scheduled with psych. (b)(6); (b)(7)(C) States being at Cibola for 5months and not recieving medical/mental health attention. Medical chart porved otherwise (b)(6); (b)(7)(C) States being at Cibola for 15 days and not getting medical attention. Seen for PE and other appt in first 3 days. (b)(6); (b)(7)(C) Requesting anxiety medication. No anxiety diagnosis, seen twice by MH, pending psych appt for bipolar. (b)(6); (b)(7)(C) medical staff member not attentive (b)(6); (b)(7)(C) delay in ;having PE completed						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			7			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			7			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	7	1	0	3	0	1	2
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	0	Select	1	Select	Select	Select
2		Select	Select	Select	Select	Select	1
3		1	Select	Select	Select	Select	Select
4		Select	Select	1	Select	Select	Select
5		Select	Select	Select	Select	Select	1
6		Select	Select	Select	Select	1	Select
7		Select	Select	1	Select	Select	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

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HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	13	20	20
Total Met:		20	20	13	20	20
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A	Yes	Yes
4		Yes	Yes	N/A	Yes	Yes
5		Yes	Yes	N/A	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		Yes	Yes	Yes	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	Yes	Yes	Yes
16		Yes	Yes	N/A	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	Yes	Yes	Yes
20		Yes	Yes	Yes	Yes	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	10	
Total Met:		10	10	10	10	10	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	Yes	
10		Yes	Yes	Yes	Yes	Yes	

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MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018				

Facility (f)		
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?	Y
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?	25
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?	0
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.	70
fMAR-5:	OTCs provided by medical, commissary or both?	Both

Clinical (c)	
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

Total Applicable:			2	0					
Total Met:			0	0					
% Compliance:	0%		0%						
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	5	No	N/A - NLOS					
2		4	N/A - NLOS	N/A - NLOS					
3		0	N/A - NLOS	N/A - NLOS					
4		9	N/A - NLOS	N/A - NLOS					
5		0	N/A - NLOS	N/A - NLOS					
6		2	N/A - NLOS	N/A - NLOS					
7		0	N/A - NLOS	N/A - NLOS					
8		0	N/A - NLOS	N/A - NLOS					
9		39	No	N/A - NLOS					
10		2	N/A - NLOS	N/A - NLOS					

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(b)(6);
(b)(7)(C)

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	
Reviewer:	[redacted] **Date Reviewed:** 7/31/2018

Facility (f)		
fMR-1:	Type of Medical Records?	Paper
fMR-2:	Name of Electronic Health Record?	N/A

Total Applicable:		10	10	10	10	10	10	10	5	10	4	2	0	10	10	10	10	10	10	10	0	0
Total Met:		10	10	10	10	10	10	10	5	10	4	2	0	10	10	10	10	10	10	10	0	0
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A

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MENTAL HEALTH SCREEN								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.							
Sample:	10 randomly selected intake screens with positive mental health screens, if available.							
Guidelines:								
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	7/31/2018			
Clinical (c)								
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
Total Applicable:		10						
Total Met:		10						
% Compliance:	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHS-1**						
1	(b)(6); (b)(7)(C)	Yes						
2		Yes						
3		Yes						
4		Yes						
5		Yes						
6		Yes						
7		Yes						
8		Yes						
9		Yes						
10		Yes						

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:									
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	7/31/2018				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	9						
Total Met:		10	9						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	N/A - LOS						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	ICE female detainees are not detained at Cibola County Correctional Center						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Select			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	7/31/2018		

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	6
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			10	10	10	10
Total Met:			10	10	10	10
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		Constant (1:1)	Yes	Yes	Yes	No
10		Constant (1:1)	Yes	Yes	Yes	No

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		4					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	Medical record did not reflect an assessment for ADL needs was conducted; however, accomodations were provided as needed such as low bunk.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	7/31/2018		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		4	4	4	0		
Total Met:		4	0	4	0		
% Compliance:	67%	100%	0%	100%			
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1	(b)(6); (b)(7)(C)	Yes	No	Yes	N/A - NLOS		
2		Yes	No	Yes	N/A - NLOS		
3		Yes	No	Yes	N/A - NLOS		
4		Yes	No	Yes	N/A - NLOS		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

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URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**		7/31/2018	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	9	8	
Total Met:			9	10	10	8	8	
% Compliance:	96%		90%	100%	100%	89%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Back Pain	Yes	Yes	Yes	Yes	Yes	
2		Constipation	Yes	Yes	Yes	No	N/A - NLOS	
3		Leg Pain	Yes	Yes	Yes	Yes	Yes	
4		Elevated BP	Yes	Yes	Yes	Yes	Yes	
5		Elevated BP	Yes	Yes	Yes	Yes	Yes	
6		Cough	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
7		Headache	No	Yes	Yes	Yes	Yes	
8		Chest Pain	Yes	Yes	Yes	Yes	Yes	
9		Back Pain	Yes	Yes	Yes	Yes	Yes	
10		Rectal Bleeding	Yes	Yes	Yes	Yes	Yes	

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
05/14/2019	07/31/2018	Cibola County Correctional Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
177	151	0	26	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)	Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)
Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021	Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

• 4.3 Medical Care, II Expected Outcomes, 4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up
Findings: Through detainee interviews and chart reviews, CCCC medical is not providing timely follow-up when requested through the sick call process.

• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
Findings: There are (b)(7)(E) doing each an average of 25 hours a week. This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in 136 hours of overtime.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
54	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. The facility uses BOP guidelines for chronic illnesses.

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Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported hunger strikes in the last 12 months. Review of facility hunger strike policy noted to follow PBNDS 2011 standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	16

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 9 suicide watch medical records since the last site visit noted to comply with PBNDS 2011 standards. All were placed on 1:1 constant watch, and every 15 minute documentation of patient observation was noted in the medical charts. Review of medical staff training records had required suicide prevention and intervention documentation. The review of the security officer's suicide watch form by medical staff is not documented.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS 2011 standards. The review on one medical recorded death in the last 12 months showed the facility had treated the detainee with PBNDS 2011 standards. Detainee was identified as needing further medical attention during the intake medical screening, transported to the hospital, and succame to complications from their chronic medical conditions.

Other Observations

Site Visit from 5/14/2019 to 5/16/2019. A total of 114 medical records were reviewed during this site visit.

Facility Data:
IGSA operated by CoreCivic, with the medical department operated by Wellpath.
Maximum facility population is 1100, and ICE maximum population is dependent on space available with USM and county prisoners. ICE contract has a guarantee minimum of 150 detainees; current ICE population is 177. The facility houses males and transgenders in all 3 ICE custody classifications. The facility has a dedicated transgender dorm capable of housing up to 60 detainees who identify themselves as female. Current total custody population with ICE, USM, and county prisoners is at 1043.

Current Staffing:
(b)(7)(E)

Type of Medical Records: Paper charts. Wellpath is currently looking into companies providing software for Electronic Health Records (EHR).

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The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be used as suicide watch rooms.

--Reviewed (b)(7)(E) Licensed personnel had current copies of licensure and up-to-date BLS certification.
--Documentation of required annual training is complete.
--Man-Down drills have been conducted and documented; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Facility has a full time pharmacy tech on staff. Medication refrigerator temperature logs checked and accurate. Quarterly pharmacist inspection and certification was documented.
--Medical housing, suicide watch, and segregation areas observed. The review of the security officer's suicide watch form by medical staff is not documented
--Lab area refrigerator temperature log verified and accurate. CLIA license was current.
--Over-the-Counter (OTC) medication is provided in medical and in commissary with the clinical director's and health authority's documented approval.
--Medical diets are available and ordered. The diets were renewed at least every 90 days when continuance needed.
--Transgender housing and care is based on the PBNDS 2011 standards; no issues were identified.

Deficiencies for Areas Evaluated

PBNDS 2011:

• 4.3 Medical Care, II Expected Outcomes, 4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up
Findings: Through detainee interviews and chart reviews, CCCC medical is not providing timely follow-up when requested through the sick call process.

• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
Findings: There are 11 full time registered nurses, along with 5 as needed nurses doing each an average of 25 hours a week. This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in 136 hours of overtime.

QMC Tools:

• Diabetic detainees are not getting a documented blood sugar during the medical intake screening
• Detainees with asthma are not getting peak flow measurements during the initial health assessment or each chronic care visit
• Detainees with disabilities do not have documentation of being assessed for needed assistance with ADLs (Activities of Daily Living)
• Time urgency is not documented by providers on referrals to outside specialties

Other Finding:

• The review of the security officer's suicide watch form by medical staff is not documented
• Documentation of after-hours sick call requests due to non-urgent issues is not done. documented.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to the QMC Tools.

Health Assessment

Refer to the QMC Tools.

Urgent Care (Sick Call)

Refer to the QMC Tools.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to the QMC Tools.

Medication Administration Practices

Refer to the QMC Tools.

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Continuity of Medication

Refer to the QMC Tools.

Mental Health Screen

Refer to the QMC Tools.

Medical Recordkeeping Practices

Refer to the QMC Tools.

Pregnant Women

ICE Females are not detained at the facility at this time.

Dental Care

Refer to the QMC Tools.

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Acute Laboratory Testing

Refer to the QMC Tools.

Diagnostic Services and Specialty Care Access

Refer to the QMC Tools.

Mental Health Treatment Planning

Refer to the QMC Tools.

Treatment of Disability

Refer to the QMC Tools.

Complaints and Grievances

Refer to the QMC Tools.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to the QMC Tools.

Human Immunodeficiency Virus (HIV)

Refer to the QMC Tools.

Hypertension

Refer to the QMC Tools.

Asthma

Refer to the QMC Tools.

Seizure Disorder

Refer to the QMC Tools.

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Recommendations

Address PBNDS 2011 Standards and Quality of Care issues below:

PBNDS 2011:

• 4.3 Medical Care, II Expected Outcomes, 4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up
Findings: Through detainee interviews and chart reviews, CCCC medical is not providing timely follow-up when requested through the sick call process.

• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
Findings: There are 11 full time registered nurses, along with 5 as needed nurses doing each an average of 25 hours a week . This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in 136 hours of overtime.

QMC Tools:

• Diabetic detainees are not getting a documented blood sugar during the medical intake screening
• Detainees with asthma are not getting peak flow measurements during the initial health assessment or each chronic care visit
• Detainees with disabilities do not have documentation of being assessed for needed assistance with ADLs (Activities of Daily Living).
• Time urgency is not documented by providers on referrals to outside specialties

Other Finding:

• The review of the security officer’s suicide watch form by medical staff is not documented
• Documentation of after-hours sick call requests due to non-urgent issues is not done

Facility Actions

HSA, warden, and facility ICE personnel had a short meeting with FMC to discuss the facility findings.

Per HSA Statement:

Facility CQI program will continue along with the use of IHSC site visit tools. The PBNDS 2011 and quality of care issues will be addressed.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856 (b)(6); (b)(7)(C)	Date Prepared: 06/30/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 07/08/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/09/2019

Recommendations:

(b)(5)

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Cibola conty Correctional Center			
AOR:*	ELP			
Address:	2000 Cibola Loop, P.O. Box 3540			
City:	Milan		**County:**	Cibola
State:*	NM	**Zip:**	87021	
Inspection Information				
Start Date:*	5/14/2019			
End Date:*	5/16/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		177		
Total Facility Population at Time of Visit:		1043		
Facility Capacity:		1100		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	7/9/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by: (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	84%	
CG	Complaints and Grievance	3	*Total Number
CM	Continuity of Medications	100%	
DC	Dental Care	100%	
DM	Diabetes	96%	
DSA	Diagnostic Services and Specialty Care Access	88%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	100%	
HIV	Human Immunodeficiency Virus	100%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	83%	
UC	Urgent Care (Sick Call)	94%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(7)(E)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Other 1						
Other 2						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs (Medical Administrative Record).	
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm	
Remarks:		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/14/2019

Facility (f)		
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?	Y
fASM-1b:	If yes, what is the guideline?	BOP

Clinical (c)	
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.
cASM-2	Was a peak flow completed at the initial physical exam?
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.

Total Applicable:		10	10	9	10
Total Met:		10	7	6	10
% Compliance:	84%	100%	70%	67%	100%
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes
2		Yes	Yes	Yes	Yes
3		Yes	No	No	Yes
4		Yes	No	No	Yes
5		Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes
10		Yes	No	No	Yes

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/14/2019

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP

	Clinical (c)
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		10	10	7	7	3	1	6	7
Total Met:		7	10	7	7	3	1	6	7
% Compliance:	96%	70%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
2		No	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
3		No	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - NLOS
4		Yes	Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - LOS	N/A - LOS
5		Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	N/A - NLOS	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	N/A - LOS	N/A - NLOS	Yes	Yes	
7		No	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes	
8		Yes	Yes	Yes	N/A - LOS	N/A - LOS	N/A - NLOS	Yes	Yes	
9		Yes	Yes	Yes	Yes	N/A - LOS	N/A - LOS	Yes	Yes	
10		Yes	Yes	N/A - LOS	Yes	N/A - LOS	Yes	N/A - LOS	N/A - LOS	

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HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines http://nccc.ucsf.edu						
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	1) refused labs						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/14/2019			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			9	6	10	7	10
Total Met:			9	6	10	7	10
% Compliance:	100%		100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Recent Lab	N/A - NLOS	N/A - LOS	Yes	N/A - LOS	Yes	
2		Medical Record	Yes	Yes	Yes	Yes	Yes	
3		Medical Record	Yes	Yes	Yes	Yes	Yes	
4		Recent Lab	Yes	Yes	Yes	Yes	Yes	
5		Recent Lab	Yes	N/A - LOS	Yes	Yes	Yes	
6		Medical Record	Yes	Yes	Yes	Yes	Yes	
7		Medical Record	Yes	Yes	Yes	Yes	Yes	
8		Medical Record	Yes	Yes	Yes	Yes	Yes	
9		Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes	
10		Medical Record	Yes	N/A - LOS	Yes	N/A - LOS	Yes	

AMERICAN OVERSIGHT

HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		BOP			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	6	10	
Total Met:		10	10	6	10	
% Compliance:	100%	100%	100%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes
2		Y	Yes	N/A - NLOS	Yes
3		Y	Yes	N/A - NLOS	Yes
4		Y	Yes	N/A - NLOS	Yes
5		Y	Yes	Yes	Yes
6		Y	Yes	Yes	Yes
7		Y	Yes	N/A - NLOS	Yes
8		Y	Yes	Yes	Yes
9		Y	Yes	Yes	Yes
10		Y	Yes	Yes	Yes

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		5				
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		5	5	2	5	5
Total Met:		5	5	2	5	5
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A - LOS	Yes	Yes
2		Yes	Yes	N/A - NLOS	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	N/A - LOS	Yes	Yes
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/14/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	10
Total Met:		10	10
% Compliance:	100%	100%	100%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	10	10	5			
Total Met:		10	10	10	5			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	N/A - LOS			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	N/A - NLOS			
4		Y	Yes	Yes	N/A - NLOS			
5		Y	Yes	Yes	N/A - NLOS			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	Yes			
8		Y	Yes	Yes	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	N/A - NLOS			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019		
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			10	10	2	10	
Total Met:			5	10	2	10	
% Compliance:	88%		50%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1	(b)(6); (b)(7)(C)	Gastroenterology	Yes	Yes	N/A - NLOS	Yes	
2		Cardiology	No	Yes	N/A - NLOS	Yes	
3		Gastroenterology	No	Yes	N/A - NLOS	Yes	
4		General Surgery	No	Yes	N/A - NLOS	Yes	
5		Infectious Disease	Yes	Yes	Yes	Yes	
6		Infectious Disease	Yes	Yes	N/A - NLOS	Yes	
7		Other	Yes	Yes	N/A - NLOS	Yes	
8		Pulmonology	No	Yes	N/A - NLOS	Yes	
9		Opthalmology	Yes	Yes	N/A - NLOS	Yes	
10		Infectious Disease	No	Yes	Yes	Yes	

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.		
Source:	Emergency Department (ED) logs.		
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.		
Guidelines:	NCCHC 2014 J-E-12.		
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/14/2019

Clinical (c)

cEED-1	Is there an outbound progress note?
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.
cEED-3	Is there discharge documentation from the hospital or ED in the chart?
cEED-4	Is there an inbound assessment?
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?

Total Applicable:			10	10	10	10	10	
Total Met:			10	10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Chest pain	Yes	No	Yes	Yes	Yes	
2		Abdominal Pain	Yes	No	Yes	Yes	Yes	
3		Abdominal Pain	Yes	No	Yes	Yes	Yes	
4		Leg Pain	Yes	No	Yes	Yes	Yes	
5		Shoulder Disloction	Yes	No	Yes	Yes	Yes	
6		Testiculatr Pain	Yes	No	Yes	Yes	Yes	
7		Abdominal Pain	Yes	No	Yes	Yes	Yes	
8		Dislocated Finger	Yes	No	Yes	Yes	Yes	
9		Asthma Exacerbation	Yes	No	Yes	Yes	Yes	
10		Seizure	Yes	No	Yes	Yes	Yes	

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	1) Complaining of not receiving HIV med 2) Wants to be seen for constipation and to be started on hormones 3) Wants his hypertensive medications.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				Y		
fCG-2:	How many medical grievances were submitted over the past 3 months?			3			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			3			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	3	1	0	0	0	0	2
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	Select	Select	Select	Select	1
2		1	Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select	1
4		Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019	

Clinical (c)	
cHA-1	Initial screen complete within 12 hours of booking?
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.

Total Applicable:		20	20	10	15	20
Total Met:		20	20	10	15	20
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	N/A - NLOS	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	N/A	N/A - NLOS	Yes
4		Yes	Yes	N/A	N/A - NLOS	Yes
5		Yes	Yes	N/A	N/A - NLOS	Yes
6		Yes	Yes	N/A	N/A - NLOS	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		Yes	Yes	N/A	Yes	Yes
12		Yes	Yes	Yes	Yes	Yes
13		Yes	Yes	Yes	Yes	Yes
14		Yes	Yes	Yes	Yes	Yes
15		Yes	Yes	Yes	Yes	Yes
16		Yes	Yes	Yes	Yes	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	N/A	Yes	Yes
20		Yes	Yes	N/A	Yes	Yes

AMERICAN OVERSIGHT

LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	6	
Total Met:		10	10	10	10	6	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	N/A - LOS	
7		Yes	Yes	Yes	Yes	N/A - LOS	
8		Yes	Yes	Yes	Yes	N/A - LOS	
9		Yes	Yes	Yes	Yes	N/A - LOS	
10		Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS					
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10				
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.				
Source:	MARS.				
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.				
Guidelines:					
Remarks:	The facility currently uses paper MARs. MARs with blank spaces for prescribed medications had documentation on why medication was not administered/missed. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee identification card. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.				
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/14/2019	
Facility (f)					
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?			Y	
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?			10	
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?			0	
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.			75	
fMAR-5:	OTCs provided by medical, commissary or both?			Both	
Clinical (c)					
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?				
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?				
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)				

Total Applicable:				1	1				
Total Met:				1	1				
% Compliance:	100%			100%	100%				
Patient(s)	**A# (numbers only)**		**cMAR-1**	**cMAR-2**	**cMAR-3**				
1	(b)(6); (b)(7)(C)		0	N/A - NLOS	N/A - NLOS				
2			1	N/A - NLOS	N/A - NLOS				
3			6	Yes	Yes				
4			3	N/A - NLOS	N/A - NLOS				
5			0	N/A - NLOS	N/A - NLOS				
6			6	N/A - NLOS	N/A - NLOS				
7			3	N/A - NLOS	N/A - NLOS				
8			0	N/A - NLOS	N/A - NLOS				
9			2	N/A - NLOS	N/A - NLOS				
10			3	N/A - LOS	N/A - NLOS				

AMERICAN OVERSIGHT

(b)(6);
(b)(7)(C)

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	Wellpath is currently looking into companies providing software for Electronic Health Records
Reviewer:	[redacted] **Date Reviewed:** 5/14/2019

Facility (f)		
fMR-1:	Type of Medical Records?	Paper
fMR-2:	Name of Electronic Health Record?	N/A

Total Applicable:		10	10	10	10	10	8	7	4	10	7	9	3	2	10	10	10	10	10	10	0	0
Total Met:		10	10	10	10	10	8	7	4	10	7	9	3	2	10	10	10	10	10	10	0	0
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Select	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
9		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
10		Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A

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MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:									
Reviewer:		(b)(6); (b)(7)(C)		**Date Reviewed:**	5/14/2019				
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	ICE Females are not detained at the facility at this time.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			N/A			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1	None	Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	9					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/14/2019		

Facility (f)		
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?	9
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?	Y
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?	Y

Clinical (c)	
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?
cSS-2	Were checks documented consistently?
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.

Total Applicable:			9	9	9	9
Total Met:			9	9	9	9
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		Constant (1:1)	Yes	Yes	Yes	No
7		Constant (1:1)	Yes	Yes	Yes	No
8		Constant (1:1)	Yes	Yes	Yes	No
9		Constant (1:1)	Yes	Yes	Yes	No
10		Select	Select	Select	Select	Select

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TREATMENT OF DISABILITY						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		9				
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.					
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.					
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.					
Guidelines:	NCCHC J-G-02.					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019	
Facility (f)						
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y	
Clinical (c)						
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?					
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?					
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?					
cTD-4	Was ADL assistance provided, if applicable?					
Total Applicable:		9	9	9	1	
Total Met:		9	3	9	1	
% Compliance:	83%	100%	33%	100%	100%	
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**	
1	(b)(6); (b)(7)(C)	Yes	No	Yes	N/A - NLOS	
2		Yes	No	Yes	N/A - NLOS	
3		Yes	No	Yes	Yes	
4		Yes	Yes	Yes	N/A - NLOS	
5		Yes	Yes	Yes	N/A - NLOS	
6		Yes	No	Yes	N/A - NLOS	
7		Yes	Yes	Yes	N/A - NLOS	
8		Yes	No	Yes	N/A - NLOS	
9		Yes	No	Yes	N/A - NLOS	
10		Select	Select	Select	Select	

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URGENT CARE (SICK CALL)							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.						
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
Remarks:	1) submitted 9/23/18, triaged 9/27/2019 3) 7 days for kidney pain complaint 8) diarrhea resolved by 7th day when called appointment. One complaint was not triaged in a timely manner, whether the detainee had put the appropriate date or had held on to the written request could not be verified; otherwise, all other reviewed requests were triaged the following day of the submitted request. Documentation of after-hours sick call requests due to non-urgent issues is not done. The urgent care room had appropriate supplies and equipment needed for urgent/emergent care within the capabilities stated in facility policy (BLS).						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/14/2019		
Clinical (c)							
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
cUC-2	Was care delivered within the scope of the nurse's license?						
cUC-3	Were vital signs documented during the nurse's assessment?						
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
Total Applicable:			10	8	8	1	2
Total Met:			7	8	8	1	2
% Compliance:	94%		70%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
1	(b)(6); (b)(7)(C)	Cold Symptoms	No	Yes	Yes	N/A - NLOS	N/A - NLOS
2		Shortness of Breath	Yes	Yes	Yes	Select	Yes
3		Kidney pain	No	Yes	Yes	Yes	Yes
4		Rectal Pain	Yes	Yes	Select	N/A - NLOS	N/A - NLOS
5		Constipation	Yes	Select	Yes	N/A - NLOS	N/A - NLOS
6		Acne	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
7		Throat Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
8		Diarrhea	No	N/A - NLOS	N/A - NLOS	N/A - NLOS	N/A - NLOS
9		Elevated Blood pressure	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
10		Cold Symptoms	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
02/04/2020	12/10/2019	Cibola County Correctional Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
48	48	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)	Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)
Address: 2000 Cibola Loop Milan, NM 87021	Address: 2000 Cibola Loop Milan, NM 87021

Medical Care

☐ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☒ >3 Standards

Description of deficiencies:

• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.

Findings: There are (b)(7)(E) doing each an average of 25 hours a week. This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in 136 hours of overtime.

FINDINGS: Non-Compliant. Cibola ICE cleared nurses includes (b)(7)(E)

(b)(7)(E)

• PBNDS 2011 4.3, II, 14., Each detainee shall receive a comprehensive medical, dental and mental health intake screening as soon as possible, but no later than 12 hours after arrival at each detention facility.

Findings: Non-Compliant. 16 of 20 (80%) had initial screen completed within 12 hours of booking. A#s: (b)(6); (b)(7)(C)

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Findings from December 2019 Site Visit:

• PBNDS 2011 4.3, IV, M - Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
DEC 2019 FINDINGS: Non-Compliant. Comprehensive health assessments are not being completed within 14 days of arrival to Cibola. 16 of 20 (80%) had a completed health assessment within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days. A#s for non-compliant charts: (b)(6); (b)(7)(C)
CURRENT FINDINGS: Non-Compliant. Comprehensive health assessments continue to not be within 14 days of arrival to Cibola after the medical staff had been educated on the standard and instructed to schedule all routine health assessments on day 10. 12 of 16 (75%) had a completed health assessment within 14 days of arrival by a mid-level provider (MLP) or physician (MD). Four were non-applicable due to being removed/released prior to 14 days at Cibola. A#s: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, V, C, 2 - …screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines
DEC 2019 FINDINGS: Non-Compliant. For a two-month period, detainees only received TB symptom screening while at the facility due to a national shortage of PPD. (Note: Chest x-ray or blood testing was not used as an option during the 2 month period.) 12 of 20 (60%) had a PPD placed during medical screen when applicable and read within 48-72. A#s for non-compliant charts: (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C)
CURRENT FINDINGS: Non-Compliant. Cibola has had PPD serum for TB testing in stock since DEC 2019 site visit. 16 of 18 (88%) had a PPD placed during medical screen when applicable and read within 48-72. A#s: (b)(6); (b)(7)(C) Two were non-applicable due to being removed/released in less than 72 hours after arriving at Cibola.

• PBNDS 2011 4.3, IV, O, 3 & 4 - Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary.
DEC 2019 FINDINGS: Non-Compliant. Seven of ten (70%) detainees referred for mental health evaluation were being evaluated by a mental health provider within 72 hours of the referral. A#s for non-compliant charts: (b)(6); (b)(7)(C)
CURRENT FINDINGS: Non-Compliant. Medical staff had received training on scheduling mental health referrals within 72 hours since the DEC 2019 site visit. Nine of ten (90%) detainees referred for mental health evaluation were evaluated by a mental health provider within 72 hours of the referral. A#: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, II, 22 - Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations.
DEC 2019 Findings: Medical staff are not receiving training in proper use of medical emergency equipment; e.g. equipment in emergency bags -- some nurses have never looked into the bag or know how to use oral airways or the manual pump.
CURRENT FINDINGS: Since the December 2019 site visit, Cibola had documented staff training on emergency response and the emergency equipment, such as the emergency response bag. However, (b)(7)(E) continued to be unfamiliar with equipment in the response bag.

• PBNDS 2011 4.3, II, 23 - Information about each detainee's health status shall be treated as confidential.
DEC 2019 FINDINGS: Security staff are handling sick call requests in order to deposit them in the medical box.
CURRENT FINDINGS: Security staff had training concerning the handling of sick call request slips, and signs have been placed in the dorms (English and Spanish) instructing detainees in the proper procedure of submitting a sick call request. Compliant.

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• PBNDS 2011 4.3, V, B - The HSA is a physician or health care professional and shall be identified to detainees.
FINDINGS: Compliant. HSA has previous history working as an HSA in correction environments.

• PBNDS 2011 4.3, V, O, 4 - The provider shall develop an overall treatment/management plan.
FINDINGS: Compliant

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
0	0

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Current total number of detainees with chronic conditions is zero, detainee charts reviewed were those that arrived after the DEC 2019 site visit and the portions of medical records of those still at Cibola after the DEC 2019 site visit.
• PBNDS 2011 4.3, IV, J - Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.
DEC 2019 FINDINGS: Non-Compliant. Seven of ten (70%) detainees identified as having chronic medical conditions had their initial chronic care/health assessment completed in 2 working days by a medical provider. A#'s for non-compliant charts: (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)
CURRENT FINDINGS: Non-Compliant. There is documentation of provider staff being trained on this standard after the DEC 2019 site visit. Seven of ten (70%) had a health assessment completed in 2 working days. A#s: (b)(6); (b)(7)(C)

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There have been no reported hunger strikes since DEC 2019 site visit. Review of facility hunger strike policy noted to follow PBNDS 2011 standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
No detainees have been placed on suicide watch since the DEC 2019 site visit. Review of medical staff training records had required suicide prevention and intervention documentation.
DEC 2019 FINDING: The review of the security officer's suicide watch form by medical staff is not documented within the medical chart.
CURRENT FINDING: Corecivic medical are developing a process on who and how often the review of the security officers suicide watch form will occur.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS 2011 standards.

Other Observations

Site Visit from 2/4/2020-2/6/2020. A total number of 48 medical records were reviewed during the site visit. There were a limited number of medical records available for review due to this site visit only reviewing the records since the December 2019 site visit.

Facility Data:
IGSA operated by CoreCivic, with the medical department operated by CoreCivic as of Sept. 14, 2019.
Maximum facility population is 1100, and ICE maximum population is dependent on space available with USM and county prisoners. ICE contract has a guarantee minimum of 150 detainees; current ICE population is 48. The facility houses males in all 3 ICE custody classifications. The facility also housed transgenders in low and medium-low until January 24, 2020. The facility has a dedicated transgender dorm capable of housing up to 60 detainees who identify themselves as female. Current total custody population with ICE, USM, and county prisoners is at 618.

Type of Medical Records: AllScripts (EHR), including the medication administration records.

The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be used as suicide watch rooms.

--Reviewed (b)(7)(E) Licensed personnel had current copies of licensure and up-to-date BLS certification.
--Documentation of required annual training is complete.
--Man-Down drills have been conducted and documented; no issues were identified but Cibola medial was recommended to complete medical man-down drills initiated by the Medical department rather than having security oversee all man-down drills.
--Pill line observed, process and procedure reviewed.
--Pharmacy area reviewed and was noted to be secure. Facility has a full-time pharmacy tech on staff. Medication refrigerator temperature logs checked and accurate. Quarterly pharmacist inspection and certification was documented.
--Medical housing, suicide watch, and segregation areas were observed.
--Lab area refrigerator temperature log verified and accurate. CLIA license was current.
With the hire of a certified medical assistant, the facility had caught up with December and January orders the week prior to this site visit.

Deficiencies for Areas Evaluated

PBNDS 2011:

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• 4.3 Medical Care, II Expected Outcomes, 21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
Findings: There are (b)(7)(E) (b)(7)(E) This is not sufficient in providing consistent care to a population of over 1000 detainees and inmates that includes detainees with high acuity conditions. This is evident in timely sick call follow ups for dental, mental health, and medical. It was also noted that within the prior week's schedule the medical staff put in (b)(7)(E)

FINDINGS: Non-Compliant. (b)(7)(E)
(b)(7)(E)

• PBNDS 2011 4.3, II, 14., Each detainee shall receive a comprehensive medical, dental and mental health intake screening as soon as possible, but no later than 12 hours after arrival at each detention facility.
Findings: Non-Compliant. 12 of 16 (80%) had initial screen completed within 12 hours of booking. A#s: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, IV, M - Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition.
FINDINGS: Non-Compliant. Comprehensive health assessments continue to not be within 14 days of arrival to Cibola after the medical staff had been educated on the standard and instructed to schedule all routine health assessments on day 10. 12 of 16 (75%) had a completed health assessment within 14 days of arrival by a mid-level provider (MLP) or physician (MD). Four were non-applicable due to being removed/released prior to 14 days at Cibola. A#s: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, V, C, 2 - …screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines
FINDINGS: Non-Compliant. Cibola has had PPD serum for TB testing in stock since the DEC 2019 site visit. 16 of 18 (88%) had a PPD placed during medical screen when applicable and read within 48-72. A#s: (b)(6); (b)(7)(C) Two were non-applicable due to being removed/released in less than 72 hours after arriving at Cibola.

• PBNDS 2011 4.3, IV, O, 3 & 4 - Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary.
FINDINGS: Non-Compliant. Medical staff had received training on scheduling mental health referrals within 72 hours since the DEC 2019 site visit. Nine of ten (90%) detainees referred for mental health evaluation were being evaluated by a mental health provider within 72 hours of the referral. A#: (b)(6); (b)(7)(C)

• PBNDS 2011 4.3, II, 22 - Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations.
FINDINGS: Since the DEC 2019 site visit, Cibola had documented training of staff on emergency response and the emergency equipment, such as the emergency response bag, but staff continue to be unfamiliar with equipment in the response bag.

• PBNDS 2011 4.3, IV, J - Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a

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health assessment no later than two working days from the initial screening.
FINDINGS: Non-Compliant. There is documentation of provider staff being trained on this standard after the DEC 2019 site visit. Seven of ten (70%) had a health assessment completed in 2 working days. A#s: (b)(6); (b)(7)(C)

QMC FINDINGS:

--Four medical staff have not completed annual or new hire TB testing per CoreCivic policy
--Medical staff orientation is established, but many staff reported not being appropriately precepted.
--Potential life threating medication error regarding insulin administration was noted and prevented by the El Paso Field Medical Coordinator performing the Cibola site visit. The error was reported to the Cibola acting health service administrator.
--There are times when security staff are not maintaining presence during medication passes.
--Refusals are not acquired for significant medications that are not administered (e.g. anticonvulsive, diabetic, hypertension, HIV, etc.).
--Detainees not taking medications consistently or missing 3 consecutive doses are not being referred to a medical provider per facility policy.
--The review of the security officer's suicide watch form by medical staff is pending a set facility process.
--Medications are not being continued from intake.
--Detainees identified as having HIV are not seen by an infectious disease specialist within 30 days of arrival
--HIV medications are not being started in a timely manner
--Lab orders are not completed timely
--The state of chronic disease as being controlled or uncontrolled is not documented
--Orders in electronic health records are not appropriately inputted, causing delayed or missed orders. Providers are unfamiliar with inputting stat orders in the EMR.
--Transgender detainees are not being tested for STDs. A#: (b)(6); (b)(7)(C)
--Scheduling of medical appointments is unorganized and causing delays in care. All medical clinic appointments and mental health/provider/labs are inputted through medical records, who are over-tasked with other duties or are receiving incorrect requests from medical staff.
--Assessments on medical complaints are not fully investigated; trangenders were noted to have rectal bleeding but no visualization of anus was conducted. A#s: (b)(6); (b)(7)(C)
--Documentation of encounters are occurring 1-2 days after the assessment without being noted as a late entry. (b)(6); (b)(7)(C)
--Consents for psychotropic medications are not being completed when continuing medication from intake.
--Consult note was not scanned into detainee medical record after medical specialty evaluation; in so, there was no clinician acknowledgment of the report.
--Baseline HgbA1C are not being performed on diabetic detainees within 30 days of intake
--Specialty consult notes are not scanned into to medical records where clinicians and acknowledge the reports in 7 days.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

Refer to the QMC Inspection Worksheet.

Health Assessment

Refer to the QMC Inspection Worksheet.

Two of 18 (11%) did not have a PPD placed during medical screen when applicable and read within 48-72; or, if PPD was positive, a chest x-ray was ordered and read. A#s: A#s: (b)(6); (b)(7)(C)

Three of ten (30%) did not have timely follow up of a chronic condition. A#s: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

Four of 16 (25%) did not have a completed health assessment within 14 days of arrival by a mid-level provider (MLP) or physician (MD). A#s: (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C)

Urgent Care (Sick Call)

Refer to the QMC Inspection Worksheet.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

Refer to the QMC Inspection Worksheet.

Medication Administration Practices

Refer to the QMC Inspection Worksheet.

One of ten (10%) of charts had three or more refusals. A#s: (b)(6); (b)(7)(C)
Zero of one (0%) of charts that had three or more consecutive refusals did not have required documentation that the prescribing clinician was notified of the consecutive refusals, as per facility policy. A#s: (b)(6); (b)(7)(C)
Zero of one (0%) that needed referral to a provider for 3 or more refusals did not have an appropriate response from the clinician. A#: (b)(6); (b)(7)(C)

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Continuity of Medication

Refer to the QMC Inspection Worksheet.

One of four (25%) did not have medication ordered in less than 24 hours from time of completed intake screening. (b)(6); (b)(7)(C)
One of four (25%) did not have the first dose of medication administered in less than 24 hours. (b)(6); (b)(7)(C)

Mental Health Screen

Refer to the QMC Inspection Worksheet.

One of ten (10%) detainees referred for mental health evaluation were not being evaluated by a mental health provider within 72 hours of the referral. A#: (b)(6); (b)(7)(C)

Medical Recordkeeping Practices

Refer to the QMC Inspection Worksheet.

Two of ten (20%) did not have consents for psychotropic continued from intake, but did have medical consents for care. A#s: (b)(6); (b)(7)(C)
One of ten (10%) did not have results of specialty consultations and referrals (acknoledeged and dated) A#: (b)(6); (b)(7)(C)

Pregnant Women

Female ICE detainees are not housed at Cibola

Dental Care

Refer to the QMC Inspection Worksheet.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Acute Laboratory Testing

Refer to the QMC Inspection Worksheet.

Zero of four (0%) had blood drawn or test done within 1 business day of the ordered date.
A#s: (b)(6); (b)(7)(C)

Diagnostic Services and Specialty Care Access

Refer to the QMC Inspection Worksheet.

One of five (20%) did not have clinician acknowledgment of the specialist's report in the medical record within 7 days of the date the service was performed. A#: (b)(6); (b)(7)(C)

Mental Health Treatment Planning

Refer to the QMC Inspection Worksheet.

Treatment of Disability

Refer to the QMC Inspection Worksheet.

Complaints and Grievances

Refer to the QMC Inspection Worksheet.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

Refer to the QMC Inspection Worksheet.

One of Three (33%) did not have a baseline HgbA1c performance within 30 days. A#: (b)(6); (b)(7)(C)
One of Three (33%) did not have degree of control (goal HgbA1C) documented. A#: (b)(6); (b)(7)(C)

Human Immunodeficiency Virus (HIV)

Refer to the QMC Inspection Worksheet.

One of two (50%) was not seen by an HIV/ID specialist within 30 days of identification. A#s: (b)(6); (b)(7)(C)

Hypertension

Refer to the QMC Inspection Worksheet.

Asthma

Refer to the QMC Inspection Worksheet.

Seizure Disorder

Refer to the QMC Inspection Worksheet.

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Recommendations

(b)(5)

Facility Actions

HSA, warden, and several CoreCivic detention and medical representatives had a short meeting with FMCs to discuss the facility findings.

Per CoreCivic warden and (a)HSA, all deficiencies will be addressed promptly.

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Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
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Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 02/12/2020
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Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 02/15/2020
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IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
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Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 02/21/2020

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
01/24/2017	10/26/2016	Cibola County Correctional Center
Name of Reviewer: (b)(6); (b)(7)(C)		Area of Responsibility/Field Office: El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
149	149	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
0	0	0	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285-(b)(6); (b)(7)(C)	Phone Number: +1 (505) 285-(b)(6); (b)(7)(C)
Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021	Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

PBNDS Medical Care 4.3 E. Facilities shall provide appropriate interpretation and language services for LEP (Limited English Proficiency) detainees...
FINDINGS: Forms requiring detainee signatures did not have an area for documentation of the use or non-use of a translator.(Patient speaks English, Provider fluent in patient's language, or translator used with translator name/number and language)

PBNDS Medical Care 4.3 I. All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. copies of the documents must be maintained on site and readily available for review.
FINDINGS: Scopes of practice for licensed non-independent providers were not documented.

PREVIOUS PRE-OCCUPANCY VISIT FINDINGS 10/26/2016:

Medical Care 4.3 V. All facilities shall provide medical staff and sufficient support personnel to meet these standards (PBNDS).
FINDINGS: Facility plan was to have (b)(7)(E) from other IGSA ICE facilities who were to be temporarily on-site to assist with the initial opening and ramp up of the facility, and (b)(7)(E) that worked at the facility during BOP occupancy were scheduled to return.
CORRECTIVE ACTION & CURRENT STATUS: Staffing levels have increased and ICE is limiting amount of detainees at the facility and adjusting population based on e-QIP clearance of new staff.

Medical Care 4.3 F.1. Adequate space and equipment shall be furnished in all facilities so

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that all detainees may be provided basic health examinations and treatment in private while ensuring safety.
FINDINGS: Intake space lacked a designated area for medical to perform intake screenings. The suggested process was to use the medical clinic as overflow, however, due to the size limitations in the medical clinic, this would severely impair the ability of the clinic to perform normal daily operations. Additionally, the mixing of TB cleared and those that are pending clearance would pose infection control challenges. Medical clinic waiting area is only able to accommodate 10 detainees at one time. Historically, the facility utilized the chapel as an overflow medical clinic waiting room. It was undetermined at the time if the chapel would be used for this purpose.
CORRECTIVE ACTION & CURRENT STATUS: Four rooms were made available in intake area for medical screening and use of translator phone lines. The chapel serves as an additional waiting area for daily medical appointments.

Medical Care 4.3 E. Facilities shall provide appropriate interpretation and language services for LEP (Limited English Proficiency) detainees related to medical and mental health care…detainees shall not be used for interpretation services during any medical or mental health service. Interpretation and translation services by other detainees shall only be provided in an emergency medical situation.
FINDINGS: Availability of a private room/area with telephone capabilities, or availability of a cordless phone to use interpretation services to communicate with detainees who have LEP, away from the intake processing desk, is not available.
CORRECTIVE ACTION & CURRENT STATUS: Four rooms were made available in intake area for medical screening and each has have use of a translator phone line.

Medical Care 4.3 Q. Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting.
FINDINGS: Sick call is completed through submitting a kite in a secured medical mail box near the medical clinic. Access to the medical mailbox is not readily available to all sections of the facility to include several dormitories.
CORRECTIVE ACTION & CURRENT STATUS: A medical mailbox was installed near each section of dormitories.

Medical Care 4.3 V.B. The CMA (Clinical Medical Authority) together with the HSA establishes the processes and procedures necessary to meet the medical standards outlined herein (PBNDS).
FINDINGS: Though the facility medical policies have been adapted from other Correct Care Solutions facilities, the actual processes/procedures must be written and communicated to medical staff.
CORRECTIVE ACTION: Staff training has occurred to inform the medical staff of established facility policies and procedures.

Medical Care 4.3 Y.4. c. Transfer of health records. (Requires a copy of the full medical record upon release or transfer of the detainee)
FINDINGS: The facility had no current plan to provide a copy of the complete medical record when a detainee transfers.
CORRECTIVE ACTION & CURRENT STATUS: The facility is no longer required to provide a copy of the full medical record according to the December 2016 revisions to PBNDS 2011.

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
22	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately.

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The facility uses BOP guidelines for chronic illnesses.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

There have been no reported hunger strikes since the intake of ICE detainees to the facility. Review of facility hunger strike policy noted to follow standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
2	2

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 2 of 2 medical records noted to comply with standards. All were placed on 1:1 constant watch and every 15 minute documentation of patient observation was noted in the medical charts.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with standards.

Other Observations

Site Visit from 1/24/2017 to 1/26/2017. A total of 54 medical records were reviewed during this site visit.

Facility Data:
IGSA operated by by Corrections Corporation of America (CCA), with the medial department operated by Correct Care Solutions (CCS).
Maximum ICE population 500, current population 149, all male facility, to include all three levels of ICE detainees.
The facility had been occupied by the Federal Bureau of Prisons until contract termination in September 2016. Contracted by ICE in October 2016.

Current Staffing:

(b)(7)(E)

Type of Medical Records: Paper charts. CCS is currently researching vendors for Electronic Health Records(EHR).

The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be

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used as suicide watch rooms.

--Reviewed (b)(7)(E) Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification. Scopes of Practice for licensed non-independent providers are not documented.
--Documentation of required annual training was incomplete due the facility currently composing official training folders (review of the items covered in medical staff training appeared to meet required standards, and this FMC will follow up on this item on the next quarterly site visit)
--One Man-Down drill has been conducted and documented since the facility received detainees.
--Sick call observed, process and procedure reviewed; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Pharmacy area reviewed and was noted to be secure. Facility has a pharmacist on staff who completes quarterly reviews; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Medical diets are available and ordered. The diets are renewed as needed.
-- Medical crash cart is secured with a metal lock and the majority of the medical staff do not have access to open the lock
-- N-95 OSHA medical evaluation and fit testing not documented (Facility was in the process of completing this item)
-- There is no record of staff varicella immunity status which may place them at risk due to the higher than normal incidents of varicella with ICE detainees.

Deficiencies for Areas Evaluated

PBNDS 2011 Deficiencies:

Medical Care 4.3 E. Facilities shall provide appropriate interpretation and language services for LEP (Limited English Proficiency) detainees...
FINDINGS: Forms requiring detainee signatures do not have an area for documentation of the use or non-use of a translator.(Patient speaks English, Provider fluent in patient's language —with stated language, or translator used with translator name/number and language)

Medical Care 4.3 I. all health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. copies of the documents must be maintained on site and readily available for review.
FINDINGS: Scopes of Practice for licensed non-independent providers are not documented in credential files.

Quality of Care Findings:

-- Vital signs are not documented on clinical visits involving mental health or dental.
-- Lab results are not being reviewed with the patients.
-- There is no documentation of the review of incoming transfer summaries
-- Insulin dependent diabetic patients are not required to be on lower bunks.
-- Medical crash cart is secured with a metal lock and the majority of the medical staff do not have access to open the lock.
-- Medical staff is not familiar with the location of medication and equipment within the crash cart and emergency bag.
-- N-95 OSHA medical evaluation and fit testing not documented (Facility currently in the process of completing this item)
-- There is no record of staff varicella immunity status

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Suicide Screening

2 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

-There have been 2 suicide watches since the facility opened.

-The facility mental health professional uses a suicide risk management screening instrument that does include the asking for a history of suicide attempts and for current suicidal ideation.

-All medical staff in direct contact with detainees are trained to assess suicide risk.

Two of two (100%) were evaluated by a mental heal professional within 24 hours of identification, and daily while on suicide watch.

Two of two (100%) were on constant 1:1 watch by a security officer with checks documented consistently.

Two of two (100%) had no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

Health Assessment

10 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had initial screenings that were completed within 12 hours of arrival.

Ten of ten (100%) had PPD placed during medical screen when applicable and read within 48-72. If PPD was positive, a chest x-ray was ordered and read.

Two of two (100%) charts with positive screening for mental illness or suicide risk were referred for evaluation.

Ten of ten (100%) had timely follow up of a chronic condition.

Ten of ten (100%) had completed health assessments within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days.

Subsequent finding: There is no documentation of the review of incoming transfer summaries during intake medical screening, either on the summary itself or on the medical screening form.

Urgent Care (Sick Call)

10 charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and documented vital signs.

Four of four (100%) had referrals submitted to the MD/MLP/DMD within 24 hours where appropriate.

Four of four (100%) that had been referred, had MD/MLP/DMD documented assessment and plan.

Sick call requests were collected and triaged at night, and non-urgent requests were evaluated the next day. The urgent care room had appropriate supplies and equipment needed for urgent/emergent care within the capabilities stated in facility policy (BLS), but staff were not familiar with the location of medication and equipment within the crash cart and emergency bag.

Subsequent finding: Vital signs are not documented on clinical visits involving mental health or dental.

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Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

2 charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Two of two (100%) had notes for each outbound emergency encounter and had no evidence that earlier intervention may have prevented the need for ED referral or admission.

Two of two(100%) had discharge documentation from the hospital/Emergency Department(ED), and an inbound assessments with no deviations from hospital/ED recommendations upon return to the facility.

Medication Administration Practices

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Zero of ten charts had three or more refusals, or consecutive refusals that would have required documentation that the prescribing clinician was notified of the consecutive refusals.

Zero of ten required referral to a provider for 3 or more refusals.

The facility currently uses paper MARs which showed no missed doses other than those that were as needed (PRN). There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee identification card. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

Lab area refrigerator temperature log verified and accurate.

Non-prescription medication is only provided in medical and not the commissary

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Continuity of Medication

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had medication ordered in less than 24 hours from time of completed intake screening.

Ten of ten (100%) had the first dose of medication administered in less than 24 hours.

Mental Health Screen

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Nine of nine (100%) that had a positive screen for mental illness or suicide risk were referred for evaluation and were evaluated by the LPC in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days).

One chart was non-applicable due to having a negative screening for mental illness.

Medical Recordkeeping Practices

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

The facility uses paper charting and CCS is currently looking into companies providing software for Electronic Health Records.

Facility medical records was found to be complaint in identifying information, current problem list, receiving screen and health assessment forms, encounters with significant findings/diagnosis/treatments/and dispositions, signed clinician orders for medications, placement of Medication Administration Records within 2 weeks of previous month, acknowledgment and dating of lab and diagnostic reports, flowsheets, consents for medial care and treatment, signing of refusals of care, documented date and time on each encounter, integrating medical/dental/mental health records, and timely filing within 72 hours.

Pregnant Women

Females are not detained at this facility at this time.

Dental Care

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) were screened for dental symptoms during the intake process.

Eight of eight (100%)were evaluated by a qualified health professional within 48 hours of request, and dental clinical notes described findings, diagnosis,treatment and plan. Two charts did not need evaluation by a qualified health professional.

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Eight of eight (100%)that were evaluated had a follow-up treatment as recommended.

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Acute Laboratory Testing

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had blood drawn or test done within 1 business day of the ordered date.

Ten of ten (100%) with non acute routine lab orders had a report of results within 7 days, clinical acknowledgment, and an appropriate clinical response.

Three of ten (30%) had documentation that the lab results were reviewed with the detainee.

Subsequent finding: Noted lab results are being acknowledged by the ordering provider, but there is no documentation that the results were reviewed with the patients.

Diagnostic Services and Specialty Care Access

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a documented time of urgency included on the order for specialty care or diagnostic services.

Ten of ten (100%) had the appointment accomplished within 45 days of the order or within the ordered time-frame, e.g. "return in 90 days."

Ten of ten (100%) specialist reports had documentation of acknowledgment by the facility clinician within 7 days of the date the service was performed.

None of the charts required re-evaluation for deterioration every 30 days until off-site service completed due to all having service completed within 30 days.

Mental Health Treatment Planning

9 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Nine of nine (100%) had a clinical assessment , treatment, and follow-up plan documented.

Nine or nine (100%) had a treatment plan updated at a minimum of every 90 days.

Treatment of Disability

0 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

The facility has had no detainees identified with a disability since receiving ICE detainees; however, there were no areas of concern noted during review of medical records, facility processes, procedures, and policy.

Complaints and Grievances

0 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

The facility has had no detainee grievances since receiving ICE detainees; however, there were no areas of concern noted during review of medical records, facility processes,

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procedures, and policy.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

3 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Three of three (100%) had blood sugar measured and recorded on intake.

Three of three (100%) were seen for chronic care by MLP/MD within fourteen days of illness identification.

Three of three (100%) had HgbA1c performance within 30 days

Three of three (100%) had lipids measured within one year.

Three of three (100%) had documentation of degree of diabetes control and a strategy to attain diabetes control when HgbA1C was above goal.

Three of three (100%) were non-applicable for being followed at least every 90 days with appropriate vital signs due to being at the facility less than 30 days.

Insulin dependent diabetic patients are not required to be on lower bunks which may place them at a higher risk for injury

Human Immunodeficiency Virus (HIV)

0 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

The facility has had no detainees identified with a HIV since receiving ICE detainees; however, there were no areas of concern noted during review of medical records, facility processes, procedures, and policy.

Hypertension

6 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Six of six (100%) had documented blood pressure reading at intake and were seen by an MD/NP within 14 days of illness identification.

Two of two (100%)whose blood pressure was >140 systolic or >90 diastolic had a treatment plan initiated within 14 days of identification.

Five of five (100%) had chronic disease guideline usage with included baseline laboratory. One was non-applicable due to removal/release prior to having ordered laboratory testing.

Asthma

3 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Three of three (100%) were seen by a provider with in 14 days of illness identification.

Three of three (100%)had peak flow completed on initial physical exam.

Three of three (100%) had peak flow completed at the Chronic Care visit.

Three of three (100%) followed chronic disease guidelines, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

Seizure Disorder

1 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

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One of one (100%) had an appropriate neurological history completed at the initial physical examination.

One of one (100%) were seen by a provider within 14 days of illness identification.

One of one (100%) had serum drug levels performed and acknowledged in the medical record at least every 3 months until stable.

One of one (100%) had a treatment plan established.

One of one (100%) had orders for a bottom bunk

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Recommendations

(b)(5)

Facility Actions

HSA, AHSA and facility ICE personnel had a short meeting with FMC to discuss issues identified.

Per HSA statements:

--Forms will be revised noting use or non-use of translator services
--Scopes of practice will be added to personnel records
--Vital signs will now be documented with all mental health and dental clinical visits
--Providers will be educated in documenting review of labs with patients and a process will be established where RNs can review normal labs with patients.
--Intake staff will be educated on documentation of reviewing transfer summaries
--Insulin dependent diabetic patients will all be assigned lower bunks
--The lock on the crash cart has been removed and a breakable locking tab is now used
--Staff will be educated on items in the emergency bags and crash chart
--N-95 OSHA medical evaluation and fit testing is now in the process of completion
--Varicela immunity status will be added to staff health records.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 01/24/2017
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Phone Number: +1 (602) 766-(b)(6); (b)(7)(C)	Date Reviewed: 03/31/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Central Regional Field Medical Coordinator
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Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 03/31/2017

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
07/07/2017	01/24/2017	Cibola County Correctional Center

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	El Paso

Accreditation Standard (check all that apply):

☐ NDS ☐ PBNDS 2008 ☒ PBNDS 2011 ☐ ACA ☐ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
186	174	0	12	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
2	0	2	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)	Phone Number: +1 (505) 285- (b)(6); (b)(7)(C)
Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021	Address: 2000 Cibola Loop, P.O. Box 3540 Milan, NM 87021

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There were no medical care deficiencies

Chronic Care

Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.

Total number with chronic conditions:	Total number with unstable chronic conditions:
33	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
The chronic care log is updated daily and documents the status and control of chronic conditions. Medical orders for chronic patients were noted to be followed appropriately. The facility uses BOP guidelines for chronic illnesses.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
There have been no reported hunger strikes since the intake of ICE detainees to the facility. Review of facility hunger strike policy noted to follow NCCHC and PBNDS standards.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	11

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of 6 suicide watch medical records since last site visit noted to comply with PBNDS standards. All were placed on 1:1 constant watch and every 15 minute documentation of patient observation was noted in the medial charts. Review of medical staff training records had required suicide prevention and intervention documentation.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
Review of facility terminal illness policy is compliant with PBNDS standards.

Other Observations

Site Visit from 6/7/2017 to 6/9/2017. A total of 96 medical records were reviewed during this site visit.

Facility Data:
IGSA operated by by Corrections Corporation of America (CCA), with the medial department operated by Correct Care Solutions (CCS).
Maximum ICE population 884, current population 186. The 3 levels of ICE detainees are males and transgenders.
The facility had been occupied by the Federal Bureau of Prisons until contract termination in September 2016. Contracted by ICE in October 2016.
The facility has a dedicated transgender dorm.

ACA certification: Not completed since ICE has contracted the facility.
Nakamoto Group: March 2017, no deficiencies.

Current Staffing:

(b)(7)(E)

These vacancies were based on facility maximum population 884, but current population is 186

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so current staffing levels are appropriate.

Type of Medical Records: Paper charts. CCS is currently looking into companies providing software for Electronic Health Records(EHR).

The Medical Housing Unit has 2 beds, both medical/negative pressure rooms that can also be used as suicide watch rooms.

--Reviewed (b)(7)(E) Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.
--Documentation of required annual training is complete.
--Man-Down drills have been conducted and documented, no issues were identified.
--Sick call observed, process and procedure reviewed; no issues were identified.
--Pill line observed, process and procedure reviewed; no issues were identified.
--Intake observed, process and procedure reviewed; n9o issues were identified.
--Pharmacy area reviewed and was noted to be secure. Facility has a pharmacist on staff who completes quarterly reviews; temperature logs checked and accurate.
--Medical housing, suicide watch, and segregation areas observed; no issues were identified.
--Lab area refrigerator temperature log verified and accurate.
--Non-prescription medication is only provided in medical and not the commissary
--Medical diets are available and ordered. The diets are renewed as needed.
--Transgender housing and care is based on the PBNDS 2011 standards, no issues were identified.

Deficiencies for Areas Evaluated

There were no deficiencies noted in the areas evaluated.

PREVIOUS SITE VISIT FINDINGS:

PBNDS Medical Care 4.3 E. Facilities shall provide appropriate interpretation and language services for LEP (Limited English Proficiency)
FINDINGS: Forms requiring detainee signatures did not have an area for documentation of the use or non-use of a translator.(Patient speaks English, Provider fluent in patient's language with stated language, or translator used with translator name/number and language)
CORRECTIVE ACTION and CURRENT STATUS: Forms requiring detainee signature have an area for documentation of use or non-use of a translator.

PBNDS Medical Care 4.3 I. All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. copies of the documents must be maintained on site and readily available for review.
FINDINGS: Scopes of Practice for licensed non-independent providers were not documented.
CORRECTIVE ACTION and CURRENT STATUS: Scopes of Practice for licensed non-independent providers are being documented and filed in medical personnel files.

Previous Quality of Care Findings:

-- Vital signs are not documented on clinical visits involving mental health or dental.
CURRENT STATUS: Vital Signs are being documented on all mental health and dental visits
-- Lab results are not being reviewed with the patients.
CURRENT STATUS: Labs are being reviewed with patients.
-- There is no documentation of the review of incoming transfer summaries.
CURRENT STATUS: Transfer summary are being signed off as being reviewed by the intake nurse.
-- Insulin dependent diabetic (IDDM) patients are not required to be on lower bunks.
CURRENT STATUS: All IDDM patients are being assigned lower bunks
-- Medical crash cart is secured with a metal lock and the majority of the medical staff do not have access to open the lock.
CURRENT STATUS: The lock on the crash cart has been removed and replaced with a breakable seal.
-- Medical staff is not familiar with the location of medication and equipment within the

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crash cart and emergency bag.
CURRENT STATUS: Staff have documented training on emergency equipment use and are familiar with medication and supplies in the crash cart and emergency bag.
-- N-95 OSHA medical evaluation and fit testing not documented (Facility was in the process of completing this item)
CURRENT STATUS: All medial staff have documented N-95 fit testing and evaluation.
-- There is no record of staff varicella immunity status
CURRENT STATUS: All staff have varicella immunity status documented in their personell health files.

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Suicide Screening

3 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

-There have been 6 suicide watches the since last site visit January 2017.
-The facility mental health professional uses a suicide risk management screening instrument that does include the asking for a history of suicide attempts and for current suicidal ideation.
-All medical staff in direct contact with detainees are trained to assess suicide risk.

Six of six (100%) were evaluated by a mental heal professional within 24 hours of identification, and daily while on suicide watch.
Six of six (100%) were on constant 1:1 watch by a security officer with checks documented consistently.
Six of six (100%) had no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

Health Assessment

20 Charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Twenty of twenty (100%) had initial screenings that were completed within 12 hours of arrival.
Twenty of twenty (100%) had PPD placed during medical screen when applicable and read within 48-72. If PPD was positive, a chest x-ray was ordered and read.
Seven of seven (100%) of charts with positive screening for mental illness or suicide risk were referred for evaluation. The other thirteen charts has negative screenings.
Twenty of twenty (100%) had timely follow up of a chronic condition.
Twenty of twenty (100%) had completed health assessments within 14 days of arrival by a mid-level provider (MLP) or physician (MD), with those with chronic conditions being seen by a MLP or MD in 2 working days.

Urgent Care (Sick Call)

10 charts were reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and documented vital signs.
Five of five (100%) had referrals submitted to the MD/MLP/DMD within 24 hours where appropriate.
Five of five (100%) that had been referred, had MD/MLP/DMD documented assessment and plan.

Sick call requests were collected and triaged at night, and non-urgent requests were evaluated the next day. The urgent care room had appropriate supplies and equipment needed for urgent/emergent care within the capabilities stated in facility policy (BLS).

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

10 charts reviewed with the IHSC Quality of Care Audit tool to evaluate this area.

Ten of ten (100%) had notes for each outbound emergency encounter and had no evidence that earlier intervention may have prevented the need for ED referral or admission.
Ten of ten(100%) had discharge documentation from the hospital/Emergency Department(ED), and an inbound assessments with no deviations from hospital/ED recommendations upon return to the facility.

Medication Administration Practices

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

-The facility currently has a policy for any prescribed medication that is not ordered as needed and is refused 3 or more times, shall be reported to a provider.
-Approximately 1% of the charts from the current month and previous month had consecutive refusals, no shows or blank spaces.
-Facility is currently up-to-date on filing of Medication Administration Records (MARs) in

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patient charts.
-Approximately 75% of patients prescribed medication are ordered by the provider as self-administered.
-Over-the-Counter (OTC) medication is only provided by the medical department.

Zero of ten charts had three or more refusals.
Zero of ten charts had three or more consecutive refusals that would have required documentation that the prescribing clinician was notified of the consecutive refusals, as per facility policy.
Zero of ten needed referral to a provider for 3 or more refusals.

The facility currently uses paper MARs. There was no evidence that staff was pre-pouring medication. Hand washing with gel hand sanitizer observed. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee identification card. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly, and quarterly pharmacist inspection and certification documented.

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Continuity of Medication

10 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had medication ordered in less than 24 hours from time of completed intake screening.
Ten of ten (100%) had the first dose of medication administered in less than 24 hours.

Mental Health Screen

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten(100%) that had a positive screen for mental illness or suicide risk were referred for evaluation and were evaluated by the mental health professional in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days).

Medical Recordkeeping Practices

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

The facility uses paper charting and CCS is currently looking into companies providing software for Electronic Health Records.

Facility medical records was found to be complaint in identifying information, current problem list, receiving screen and health assessment forms, encounters with significant findings/diagnosis/treatments/and dispositions, signed clinician orders for medications, placement of Medication Administration Records within 2 weeks of previous month, acknowledgment and dating of lab and diagnostic reports, flowsheets, consents for medial care and treatment, signing of refusals of care, documented date and time on each encounter, integrating medical/dental/mental health records, and timely filing within 72 hours.

Pregnant Women

Females are not detained at this facility at this time.

Dental Care

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) were screened for dental symptoms during the intake process.
Ten of ten (100%)were evaluated by a qualified health professional within 48 hours of request, and dental clinical notes described findings, diagnosis,treatment and plan.
Ten of ten (100%)that were evaluated had a follow-up treatment as recommended.

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Acute Laboratory Testing

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had blood drawn or test done within 1 business day of the ordered date.
Ten of ten (100%) had the report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs, clinical acknowledgment, and appropriate clinical response.
Ten of ten (100%) had documentation that the lab results were reviewed with the detainee.

Diagnostic Services and Specialty Care Access

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a documented time of urgency included on the order for specialty care or diagnostic services.
Ten of ten (100%) had the appointment accomplished within 45 days of the order or within the ordered time-frame, e.g. "return in 90 days."
Ten of ten (100%) specialist reports had documentation of acknowledgment by the facility clinician within 7 days of the date the service was performed.
None of the charts needed re-evaluation for deterioration every 30 days until off-site service completed due to all having service completed within 30 days.

Mental Health Treatment Planning

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had a clinical assessment , treatment, and follow-up plan documented.
Ten of ten (100%) had a treatment plan updated at a minimum of every 90 days.

Treatment of Disability

5 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Five of five (100%) had the disability prominently noted in the file, along with any needed accommodations.
Five of five (100%) had been assessed for assistance with activities of daily living (ADL) upon identification of disability.
Five of five (100%) had appropriate accommodation ordered and entered

All were non-applicable with providing ADL assistance due to all having the ability to complete ADLs without any assistance.

Complaints and Grievances

0 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.

The facility has had no detainee grievances since receiving ICE detainees; however, there were no areas of concern noted during review of medical records, facility processes, procedures, and policy.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had blood sugar measured and recorded on intake.
Ten of ten (100%) were seen for chronic care by MLP/MD within fourteen days of illness identification.
Ten of ten (100%) had HgbA1c performance within 30 days
Ten of ten (100%) had lipids measured within one year.
Ten of ten (100%) were followed at least every 90 days with appropriate vital signs.
Four of four(100%) had aspirin prescribed as clinically indicated.
Ten of ten (100%) had documentation of degree of diabetes control
Six of six (100%) had a strategy to attain diabetes control when HgbA1C was above goal. The other four were non-applicable due to HgbA1C being below the goal.

Human Immunodeficiency Virus (HIV)

4 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Four of four (100%) had HIV status identified by prior medical records and had antiretroviral treatment considered and documented, and seen by an HIV or Infectious Disease specialist within 30 days of HIV identification.
Four of four(100%) had CD4+ and viral load completed within 14 days of arrival or within the last 3 months.
Four of four (100%) were seen by a mid-level provider or physician for chronic care at least every 90 days.
Four of four (100%) had a chest x-ray completed within 72 hours of problem identification, if not already done.

Hypertension

10 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

Ten of ten (100%) had documented blood pressure reading at intake and were seen by an MD/NP within 14 days of illness identification.
Eight of eight (100%) whose blood pressure was >140 systolic or >90 diastolic had a treatment plan initiated within 14 days of identification. The other two had normal blood pressures.
Ten of ten (100%) had chronic disease guideline usage with included baseline laboratory.

Asthma

1 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

One of one (100%) were seen by a provider with in 14 days of illness identification.
One of one (100%)had peak flow completed on initial physical exam.
One of one (100%) had peak flow completed at the Chronic Care visit.
One of one (100%) followed chronic disease guidelines, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

Seizure Disorder

1 charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.

One of one (100%) had an appropriate neurological history completed at the initial physical examination.
One of one (100%) were seen by a provider within 14 days of illness identification.
One of one (100%) had serum drug levels performed and acknowledged in the medical record at

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least every 3 months until stable.
One of one (100%) had a treatment plan established.
One of one (100%) had orders for a bottom bunk

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Recommendations

(b)(5)

Facility Actions

HSA, warden, and facility ICE personnel had a short meeting with FMC to discuss the facility findings.

Per HSA Statement:

Facility CQI program will continue along with the use of IHSC site visit tools.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (915) 856-(b)(6); (b)(7)(C)	Date Prepared: 07/10/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (602) 766-(b)(6); (b)(7)(C)	Date Reviewed: 08/02/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (202) 507-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 08/02/2017

Recommendations:

(b)(5)

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COMPLAINTS AND GRIEVANCES

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no no If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? _____

What percentage of this number were appropriately addressed within 5 working days of receipt? _____%

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	0	
Denial or refusal of specific request(s) for care	0	
Delay(s) in care	0	
Competency/professional skillset of medical staff	0	
Attitude, demeanor or conduct of staff	0	
Other	0	
Total	0	

NCCHC 2014 J-A-06, J-A-11.

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COMPLAINTS AND GRIEVANCES

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

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Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 0

What percentage of this number were appropriately addressed within 5 working days of receipt? N/A %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	0	
Denial or refusal of specific request(s) for care	0	
Delay(s) in care	0	
Competency/professional skillset of medical staff	0	
Attitude, demeanor or conduct of staff	0	
Other	0	
Total	0	

NCCHC 2008 J-A-06, J-A-11.

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CONTINUITY OF MEDICATION

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

Reviewed February 2017

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CONTINUITY OF MEDICATION

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County CorrectionalCenter

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 /10 100 %	10 /10 100 %

KEY: NA= not applicable

Revised May 2014

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DHS-ICE-20-0618-A-002752

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Cibola conty Correctional Center			
AOR:*	ELP			
Address:	2000 Cibola Loop, P.O. Box 3540			
City:	Milan		**County:**	Cibola
State:*	NM	**Zip:**	87021	
Inspection Information				
Start Date:*	12/10/2019			
End Date:*	12/12/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		137		
Total Facility Population at Time of Visit:		779		
Facility Capacity:		1100		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	12/18/2019
Signature:	X			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma		
CG	Complaints and Grievance	0	*Total Number
CM	Continuity of Medications	75%	
DC	Dental Care	100%	
DM	Diabetes	50%	
DSA	Diagnostic Services and Specialty Care Access		
EED	Evaluation of Care Prior to Emergency Department	20%	
HA	Health Assessment	84%	
HIV	Human Immunodeficiency Virus	75%	
HTN	Hypertension	92%	
LT	Laboratory Testing	80%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	14%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	95%	
PG	Pregnant Women		
SZ	Seizure Disorder		
SS	Suicide Screening	100%	
TD	Treatment of Disability		
UC	Urgent Care (Sick Call)	96%	

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IGSA STAFFING MATRIX						
*1 FTE = 40 hours / per week						
Position	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
C.N.A.	(b)(5)					
Dental Assistant						
Dentist						
EMT						
H.S.A.						
LVN/LPN						
MH Counselor						
MRT						
NP/PA						
Nurse Manager						
Paramedic						
Pharmacist						
Pharmacy Tech						
Physician						
Psychiatrist						
Psychologist						
RN						
Social Worker						
X-ray Tech						
Administrative Assistant						
Interpretor						
TOTAL						

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

AMERICAN OVERSIGHT

• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

AMERICAN OVERSIGHT

ASTHMA (MODERATE AND SEVERE)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs (Medical Administrative Record).							
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
Remarks:	No Asthma patients during site visit.							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019			
Facility (f)								
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y			
fASM-1b:	If yes, what is the guideline?		BOP					
Clinical (c)								
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cASM-2	Was a peak flow completed at the initial physical exam?							
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?							
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
Total Applicable:		0	0	0	0			
Total Met:		0	0	0	0			
% Compliance:								
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
1		Select	Select	Select	Select			
2		Select	Select	Select	Select			
3		Select	Select	Select	Select			
4		Select	Select	Select	Select			
5		Select	Select	Select	Select			
6		Select	Select	Select	Select			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	2	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 12/10/2019

Facility (f)		
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	BOP

Clinical (c)	
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		2	1	1	1	0	0	1	1
Total Met:		2	1	0	1	0	0	0	0
% Compliance:	50%	100%	100%	0%	100%			0%	0%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	No	Yes	N/A - LOS	N/A - LOS	No	No
2		Yes	N/A - LOS	N/A - LOS	N/A - LOS	N/A - NLOS	N/A - NLOS	N/A - NLOS	N/A - NLOS
3		Select	Select	Select	Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select	Select	Select

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6		Select	Select	Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines http://nccc.ucsf.edu						
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/10/2019			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	BOP					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						
Total Applicable:			5	5	5	5	4
Total Met:			4	1	5	5	3
% Compliance:	75%		80%	20%	100%	100%	75%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Patient Interview	Yes	No	Yes	Yes	Yes	
2		Patient Interview	Yes	No	Yes	Yes	Yes	
3		Medical Record	Yes	No	Yes	Yes	Yes	
4		Patient Interview	Yes	Yes	Yes	Yes	N/A - NLOS	
5		Medical Record	No	No	Yes	Yes	No	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

HYPERTENSION								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4							
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
Source:	Chronic disease registry or MARs.							
Sample:	10 patients with hypertension chosen at random, if available.							
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/10/2019					
Facility (f)								
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?		Y					
fHTN-1b:	If yes, what is the guideline?		BOP					
Clinical (c)								
cHTN-1	Was a blood pressure reading noted at intake?							
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?							
Total Applicable:		4	4	3	3			
Total Met:		4	4	3	2			
% Compliance:	92%	100%	100%	100%	67%			
Patient(s)	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	N/A - LOS	N/A - NLOS			
3		Y	Yes	Yes	No			
4		Y	Yes	Yes	Yes			
5		Select	Select	Select	Select			
6		Select	Select	Select	Select			
7		Select	Select	Select	Select			
8		Select	Select	Select	Select			
9		Select	Select	Select	Select			
10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	No Patients for Seizure Disorder during Site Visit					
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/10/2019		
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	BOP				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		0	0	0	0	0
Total Met:		0	0	0	0	0
% Compliance:						

Patient(s)	A# (numbers only)	cSZ-1	cSZ-2	cSZ-3	cSZ-4	cSZ-5
1		Select	Select	Select	Select	Select
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	4		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/10/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		4	4
Total Met:		3	3
% Compliance:	75%	75%	75%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	Yes
2		Yes	Yes
3		No	No
4		Yes	Yes
5		Select	Select
6		Select	Select
7		Select	Select
8		Select	Select
9		Select	Select
10		Select	Select

AMERICAN OVERSIGHT

DENTAL CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess compliance with detention standards and continuity of care.							
Source:	Dental sick call list or dental referral log.							
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
Remarks:								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019			
Clinical (c)								
cDC-1	Was patient screened for symptoms during the intake process?							
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?							
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
cDC-4	Was the patient scheduled for follow-up treatment as recommended?							
Total Applicable:		10	9	10	9			
Total Met:		10	9	10	9			
% Compliance:	100%	100%	100%	100%	100%			
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes			
2		Y	Yes	Yes	Yes			
3		Y	Yes	Yes	Yes			
4		Y	Yes	Yes	Yes			
5		Y	N/A - NLOS	Yes	Yes			
6		Y	Yes	Yes	Yes			
7		Y	Yes	Yes	N/A - NLOS			
8		Y	Yes	Yes	Yes			
9		Y	Yes	Yes	Yes			
10		Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0						
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.						
Source:	Referrals log, medical records or MedPars.						
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
Remarks:	No Diagnostic Services and Specialty						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/10/2019			
Clinical (c)							
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?						
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
Total Applicable:			0	0	0	0	
Total Met:			0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	1		
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.		
Source:	Emergency Department (ED) logs.		
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.		
Guidelines:	NCCHC 2014 J-E-12.		
Remarks:			
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/10/2019

Clinical (c)	
cEED-1	Is there an outbound progress note?
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.
cEED-3	Is there discharge documentation from the hospital or ED in the chart?
cEED-4	Is there an inbound assessment?
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?

Total Applicable:			1	1	1	1	1
Total Met:			0	1	0	0	0
% Compliance:	20%		0%	100%	0%	0%	0%
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
1	(b)(6); (b)(7)(C)	Head Injury	No	No	No	No	No
2			Select	Select	Select	Select	Select
3			Select	Select	Select	Select	Select
4			Select	Select	Select	Select	Select
5			Select	Select	Select	Select	Select
6			Select	Select	Select	Select	Select
7			Select	Select	Select	Select	Select
8			Select	Select	Select	Select	Select
9			Select	Select	Select	Select	Select
10			Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	0						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	No Grievances have been filed since the medical transition form Wellpath to CoreCivic						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			0			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			0			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	0	0	0	0	0	0	0
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1		Select	Select	Select	Select	Select	Select
2		Select	Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	19	19	20
Total Met:		20	12	19	15	16
% Compliance:	84%	100%	60%	100%	79%	80%
Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes
2		Yes	No	Yes	Yes	Yes
3		Yes	Yes	Yes	No	No
4		Yes	Yes	Yes	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	Yes
8		Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		Yes	No	Yes	N/A - NLOS	Yes
12		Yes	No	Yes	No	Yes
13		Yes	Yes	Yes	No	Yes
14		Yes	No	Yes	Yes	Yes
15		Yes	No	Yes	Yes	Yes
16		Yes	Yes	Yes	Yes	No
17		Yes	Yes	Yes	Yes	Yes
18		Yes	No	Yes	Yes	No
19		Yes	No	N/A	No	No
20		Yes	No	Yes	Yes	Yes

AMERICAN OVERSIGHT

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		3					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:							
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		3	3	3	2	2	
Total Met:		2	2	2	2	2	
% Compliance:	80%	67%	67%	67%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	Yes	
3		No	No	No	N/A - LOS	N/A - LOS	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019				
Facility (f)									
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y				
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				30				
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0				
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				70				
fMAR-5:	OTCs provided by medical, commissary or both?				Both				
Clinical (c)									
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?								
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?								
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)								
Total Applicable:			7	7					
Total Met:			1	1					
% Compliance:	14%		14%	14%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	5	No	No					
2		2	Yes	Yes					
3		1	N/A - NLOS	N/A - NLOS					
4		1	N/A - NLOS	N/A - NLOS					
5		4	No	No					
6		4	No	No					
7		7	No	No					
8		0	N/A - NLOS	N/A - NLOS					
9		2	No	No					
10		14	No	No					

AMERICAN OVERSIGHT

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 12/10/2019

Facility (f)			
fMR-1:	Type of Medical Records?	Select	
fMR-2:	Name of Electronic Health Record?	AllScripts	

Total Applicable:		10	10	10	10	10	9	9	9	10	0	0	0	0	0	10	10	10	10	10	10	10
Total Met:		10	10	10	10	10	9	9	9	10	0	0	0	0	0	10	10	10	10	10	10	10
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%						100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN										
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10									
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.									
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.									
Sample:	10 randomly selected intake screens with positive mental health screens, if available.									
Guidelines:										
Remarks:										
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	12/10/2019							
Clinical (c)										
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.									
Total Applicable:		10								
Total Met:		10								
% Compliance:	100%	100%								
Patient(s)	**A# (numbers only)**	**cMHS-1**								
1	(b)(6); (b)(7)(C)	Yes								
2		Yes								
3		Yes								
4		Yes								
5		Yes								
6		Yes								
7		Yes								
8		Yes								
9		Yes								
10		Yes								

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:									
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	4						
Total Met:		9	4						
% Compliance:	95%	90%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	N/A - LOS						
3		Yes	N/A - LOS						
4		No	N/A - LOS						
5		Yes	N/A - LOS						
6		Yes	N/A - NLOS						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	N/A - LOS						
10		Yes	Yes						

AMERICAN OVERSIGHT

PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	ICE females are not housed at Cibola at this time						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Select			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	1					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	12/10/2019		
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?		1			
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?		Y			
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?		Y			
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Total Applicable:			1	1	1	1
Total Met:			1	1	1	1
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Select	Select	Select	Select	Select
3		Select	Select	Select	Select	Select
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	No disabled patients at facility since transition from WellPath to CoreCivic						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	12/10/2019		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				N		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		0	0	0	0		
Total Met:		0	0	0	0		
% Compliance:							
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1		Select	Select	Select	Select		
2		Select	Select	Select	Select		
3		Select	Select	Select	Select		
4		Select	Select	Select	Select		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:								
Reviewer:		(b)(6); (b)(7)(C)			**Date Reviewed:**		12/10/2019	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	6	8	
Total Met:			10	10	8	6	8	
% Compliance:	96%		100%	100%	80%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	depression	Yes	Yes	Yes	N/A - NLOS	Yes	
2		hernia	Yes	Yes	Yes	Yes	Yes	
3		Dental	Yes	Yes	Yes	N/A - NLOS	Yes	
4		foot injury	Yes	Yes	Yes	Yes	Yes	
5		Hormone therapy question	Yes	Yes	No	Yes	Yes	
6		headache	Yes	Yes	Yes	Yes	Yes	
7		sore throat	Yes	Yes	Yes	Yes	Yes	
8		Abdominal Pain	Yes	Yes	No	N/A - NLOS	N/A - NLOS	
9		Dental Pain	Yes	Yes	Yes	Yes	Yes	
10		Abdominal Pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	

AMERICAN OVERSIGHT

DENTAL CARE

DATE 01/24/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item # Measure

1 Was patient screened for symptoms during the intake process?
2 Was patient evaluated by a qualified health professional within 48 hours of request?
3 Do dental clinical notes describe findings, diagnosis, treatment and plans?
4 Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	NA
3		YES	YES	YES	YES
4		YES	YES	YES	NA
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	NA
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	7 / 7 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002783

DENTAL CARE

DATE 01/24/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Cibola County Correctional Center

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	NA	NO	NA
6		YES	NA	NO	NA
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	8 / 8 100 %	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

NCCHC 2008 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

Revised March 2014

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002784

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? NCCHC/Uptodate

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	NA	YES	NA	NA
2		YES	YES	YES	YES
3		NA	YES	NA	NA
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	6 / 6 100 %	8 / 8 100 %	6 / 6 100 %	6 / 6 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? NCCHC

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	NO	YES	YES
6		YES	YES	YES	YES
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	6 / 6 100 %	5 / 6 83.33333 %	6 / 6 100 %	6 / 6 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
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AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? NCCHC

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		NA	NA	NA	NA	NA
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	1 / 1 100 %	1 / 1 100 %	0 / 0 NaN %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002787

COMPLAINTS AND GRIEVANCES

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 43

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	0	
Denial or refusal of specific request(s) for care	2	(b)(6); (b)(7)(C)
Delay(s) in care	11	
Competency/professional skillset of medical staff	2	
Attitude, demeanor or conduct of staff	0	
Other	28	(b)(6); (b)(7)(C)
Total	43	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

COMPLAINTS AND GRIEVANCES

DATE 10/20/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no No If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 19

What percentage of this number were appropriately addressed within 5 working days of receipt? 95 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)	2	(b)(6); (b)(7)(C)
Denial or refusal of specific request(s) for care	3	
Delay(s) in care	5	
Competency/professional skillset of medical staff	0	
Attitude, demeanor or conduct of staff	1	(b)(6); (b)(7)(C)
Other	8	
Total	19	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATION

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item # Measure

1 Period of time from completion of intake screening to the ordering of medications less than 24 hours?

2 Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	NO
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	NO
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	8 / 10 80 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002790

CONTINUITY OF MEDICATION

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	NO
8		YES	YES
9		YES	NO
10		YES	NO
	Total	10 / 10 100 %	7 / 10 70 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DENTAL CARE

DATE 05/03/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	YES	YES
6		YES	YES	YES	NA
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	NA
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	4 / 4 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002792

DENTAL CARE

DATE 10/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item # Measure

1 Was patient screened for symptoms during the intake process?
2 Was patient evaluated by a qualified health professional within 48 hours of request?
3 Do dental clinical notes describe findings, diagnosis, treatment and plans?
4 Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002793

CHRONIC DISEASE – DIABETES

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? NCCHC

Item # Measure

1. Was blood sugar measured and recorded on intake?
2. Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3. Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4. Were lipids measured within one year?
5. Was patient followed at least every 90 days with appropriate vital signs?
6. Was aspirin prescribed, as clinically indicated?*
7. Was degree of control (goal GgbA1C<8.0) documented?
8. Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES	NA	YES	YES
2		YES	YES	YES	YES	YES	NA	YES	NA
3		NO	YES	YES	YES	YES	NA	YES	YES
4		YES	YES	NA	NA	NA	NA	NA	NA
5		YES	YES	NA	NA	NA	NA	NA	NA
6		YES	YES	YES	YES	YES	NA	YES	YES
7		NO	YES	YES	YES	YES	NA	YES	NA
8		YES	YES	YES	YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES	NA	YES	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	7 / 9 77.%	9 / 9 100%	7 / 7 100 %	7 / 7 100 %	7 / 7 100 %	1 / 1 10(%	7 / 7 100 %	4 / 4 10(%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – DIABETES

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? NCCHC/Uptodate

Item #	Measure
1	Was blood sugar measured and recorded on intake?
2	Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3	Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4	Were lipids measured within one year?
5	Was patient followed at least every 90 days with appropriate vital signs?
6	Was aspirin prescribed, as clinically indicated?*
7	Was degree of control (goal GgbA1C<8.0) documented?
8	Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NA	YES	YES	YES
2		YES	YES	YES	YES	NA	YES	YES	YES
3		YES	YES	YES	NA	NA	NA	YES	YES
4		YES	YES	YES	NA	NA	NA	YES	NA
5		YES	YES	YES	YES	NA	NA	YES	YES
6		YES	YES	YES	NA	NA	NA	YES	YES
7		YES	YES	YES	YES	NA	YES	YES	YES
8		YES	YES	YES	NA	NA	NA	YES	NA
9		YES	YES	YES	NA	NA	NA	YES	NA
10		NA	NA	NA	NA	NA	NA	NA	NA
	Total	9 /9 100%	9 /9 100%	9 /9 100%	4 /4 100%	0 /0 NaN%	3 /3 10(%	9 /9 100%	6 /6 10(%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Orthopedics	YES	YES	YES	YES
2		Other	YES	YES	N/A	YES
3		Opthalmology	YES	YES	YES	YES
4		Other	YES	YES	N/A	YES
5		Orthopedics	YES	YES	N/A	YES
6		Orthopedics	YES	YES	N/A	YES
7		Orthopedics	YES	YES	N/A	YES
8		Other	YES	YES	N/A	YES
9		Other	YES	YES	N/A	YES
10		Cardiology	YES	YES	N/A	YES
		Total	10 / 10 100%	10 / 10 100%	2 / 2 100%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002796

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Orthopedics	YES	YES	N/A	YES
2		Orthopedics	YES	YES	N/A	YES
3		Other	YES	YES	N/A	YES
4		Opthalmology	YES	YES	N/A	YES
5		Other	YES	YES	N/A	YES
6		Pulmonology	YES	YES	N/A	YES
7		Orthopedics	YES	YES	N/A	YES
8		Other	YES	YES	N/A	YES
9		Orthopedics	YES	YES	N/A	YES
10		Other	YES	YES	N/A	YES
		Total	10 / 10 100%	10 / 10 100%	0 / 0 NaN%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002797

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Abdominal Abcess	YES	NO	YES	YES	YES
2		Critical lab values	YES	NO	YES	YES	YES
3		Head injury	YES	NO	YES	YES	YES
4		Chest Pain	YES	NO	YES	YES	YES
5		Chest Pain	YES	NO	YES	YES	YES
6		Hematuria	YES	NO	YES	YES	YES
7		Hypovolemia	YES	NO	YES	YES	YES
8		Facial Abcess	YES	NO	YES	YES	YES
9		Fever, N&V	YES	NO	YES	YES	YES
10		Right Shoulder Pain	YES	NO	YES	YES	YES
			10 / 10 100 %	0 / 10 0 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002798

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Dislocation of shoulder	YES	NO	YES	YES	YES
2		Foot and ankle pain	YES	NO	YES	YES	YES
3		Infection of knee	YES	NO	YES	YES	YES
4		Chest Pain	YES	NO	YES	YES	YES
5		Acute Back Pain	YES	NO	YES	YES	YES
6		PREA	YES	NO	YES	YES	YES
7		Elbow Pain	YES	NO	YES	YES	YES
8		Abdominal Pain	YES	NO	YES	YES	YES
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			8 / 8 100 %	8 / 8 100 %	8 / 8 100 %	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002799

HEALTH ASSESSMENT

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?
2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4 Is there timely follow-up for significant findings of acute and chronic conditions?*
5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		YES	YES	NA	YES	YES
5		YES	YES	NA	YES	YES
6		YES	YES	NA	YES	YES
7		YES	YES	NA	YES	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	YES	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25

*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?
2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4 Is there timely follow-up for significant findings of acute and chronic conditions?*
5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	YES	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	NA	YES
5		YES	YES	YES	YES	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	NA	YES
8		YES	YES	NA	NA	YES
9		YES	YES	NA	NA	YES
10		YES	YES	NA	NA	YES
	Total	20 / 20 100 %	20 / 20 100 %	2 / 2 100 %	11 / 11 100 %	20 / 20 100 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV NCCHC

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Patient Interview	NO	NO	YES	NA	YES
2		Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		0 / 1 0 %	0 / 1 0 %	1 / 1 100 %	0 / 0 NaN %	1 / 1 100 %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV NCCHC/Uptodate

Item # Measure

1. How was HIV status identified? By laboratory, prior medical records or patient report?
2. Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3. Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4. Was antiretroviral treatment considered and documented?
5. Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6. Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Medical Record	YES	NA	YES	NA	NA
2		Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		1 / 1 100 %	0 / 0 NaN %	1 / 1 100 %	0 / 0 NaN %	0 / 0 NaN %

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? NCCHC

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	N/A	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		NO	YES	YES	YES
8		YES	YES	YES	N/A
9		YES	YES	YES	YES
10		NO	N/A	N/A	N/A
	Total	8 / 9 88.8%	9 / 9 100 %	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

CHRONIC DISEASE – HYPERTENSION

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES

2 If yes, what is the guideline? NCCHC/Uptodate

Item # Measure

1 Was a blood pressure reading noted at intake?

2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?

3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?

4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	N/A	YES
4		YES	YES	YES	YES
5		YES	YES	N/A	YES
6		YES	YES	YES	YES
7		YES	YES	N/A	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		NO	N/A	N/A	N/A
	Total	9 / 9 100 %	9 / 9 100 %	6 / 6 100 %	9 / 9 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002805

LABORATORY TESTING

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	NA
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	9 / 9 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002806

LABORATORY TESTING

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	YES	YES	YES
3		YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES
6		YES	YES	YES	YES	YES
7		YES	YES	YES	YES	YES
8		YES	YES	YES	YES	YES
9		YES	YES	YES	YES	YES
10		YES	YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002807

MEDICAL RECORDKEEPING PRACTICES

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☑ Electronic ☐ Both Name of Electronic Health Record: Allscripts

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	Compliant	Compliant	NA	NA	Compliant
Results of specialty consultations and referrals[7]	NA	NA	Compliant	NA	Compliant
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	Compliant	Compliant	NA	NA	NA
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☑ Electronic ☐ Both Name of Electronic Health Record: Allscripts

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	NA	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	Compliant	Compliant	NA
Results of specialty consultations and referrals[7]	NA	NA	NA	Compliant	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	Compliant	Compliant	NA	NA
Immunization records, where applicable	Compliant	Compliant	Compliant	Compliant	Compliant
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 05/03/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES

2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 10%

3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? None

4 Estimate the percentage of patients on self-administered medication ordered by a provider. 40%

5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?

2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?

3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		1	NA	NA
4		0	NA	NA
5		2	NA	NA
6		1	NA	NA
7		2	NA	NA
8		3	NA	NA
9		0	NA	NA
10		7	NA	NA
	Total		0 /0 NaN%	0 /0 NaN%

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 10/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 10%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? None
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 45%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	2	NA	NA
2		30	NO	NA
3		2	NA	NA
4		0	NA	NA
5		7	NA	NA
6		0	NA	NA
7		0	NA	NA
8		0	NA	NA
9		1	NA	NA
10		1	NA	NA
	Total		0 /1 0 %	0 /0 NaN%

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002811

MENTAL HEALTH SCREEN

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item #	Measure
1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #		1
1	(b)(6); (b)(7)(C)		YES
2			YES
3			YES
4			YES
5			YES
6			YES
7			YES
8			YES
9			YES
10			YES
	Total		10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH SCREEN

DATE 10/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #		1
1	(b)(6); (b)(7)(C)		YES
2			YES
3			YES
4			YES
5			YES
6			YES
7			YES
8			YES
9			YES
10			YES
	Total		10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		YES	YES
10		YES	YES
	Total	10 / 10 100 %	10 / 10 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002814

MENTAL HEALTH TREATMENT PLANNING

DATE 10/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	NA
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	NA
6		YES	NA
7		YES	NA
8		YES	NA
9		YES	NA
10		YES	NA
	Total	10 / 10 100 %	3 / 3 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 10/17/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? NCCHC/Uptodate

Item # Measure

1. Was an appropriate neurological history completed at the initial physical examination?
2. Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3. Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4. Was a treatment plan established?
5. Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		YES	YES	NA	YES	YES
3		YES	YES	NA	YES	YES
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	3 / 3 100 %	3 / 3 100 %	1 / 1 100 %	3 /3 100 %	3 / 3 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002816

SUICIDE SCREENING

DATE 05/02/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 26

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		YES	YES	Constant (1:1)	YES	NO
9		YES	YES	Constant (1:1)	YES	NO
10		YES	YES	Constant (1:1)	YES	NO
	Total	10 / 10 100 %	10 / 10 100 %		10 / 10 100 %	0 / 10 0 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 10/19/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 21

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	Constant (1:1)	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	Constant (1:1)	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		YES	YES	Constant (1:1)	YES	NO
9		YES	YES	At least q15min	YES	NO
10		YES	YES	Constant (1:1)	YES	NO
	Total	10 /10 100 %	10 /10 100 %		10 /10 100 %	10 /10 100 %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 05/01/2018 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Central Arizona Florence Correctional Complex-East

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes

Item # Measure

1 Is the disability prominently noted in the file, along with any needed accommodations?

2 Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?

3 Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?

4 Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	YES
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	4 / 4 100 %	4 / 4 100 %	4 / 4 100 %	1 / 1 100 %

KEY: NA = not applicable

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TREATMENT OF DISABILITY

DATE: 10/18/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Central Arizona Florence Correctional Complex-East

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? Yes

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	NA
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	3 / 3 100 %	3 / 3 100 %	3 / 3 100 %	0 / 0 NaN %

KEY: NA = not applicable

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URGENT CARE (SICK CALL)

DATE 05/01/2018 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Injured Hand	YES	YES	YES	NA	NA
2		Ingrown Toenail	YES	YES	YES	YES	YES
3		Cold symptoms	YES	YES	YES	YES	YES
4		Hand Pain	YES	YES	YES	NA	NA
5		Allergies	YES	YES	YES	NA	NA
6		Foot Fungus	YES	YES	YES	NA	NA
7		Cold Symptoms	YES	YES	YES	NA	NA
8		Dental Pain	YES	YES	YES	YES	YES
9		Back Pain	YES	YES	YES	NA	NA
10		Earache	YES	YES	YES	NA	NA
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	3 / 3 100 %	3 / 3 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

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DHS-ICE-20-0618-A-002821

URGENT CARE (SICK CALL)

DATE 10/18/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item # Measure

1 Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2 Was care delivered within the scope of the nurse's license?
3 Were vital signs documented during the nurse's assessment?
4 If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5 If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Abdominal Pain	YES	YES	YES	YES	YES
2		Earache and Sore Throat	YES	YES	YES	YES	YES
3		Earache	YES	YES	YES	YES	YES
4		Cough and Headache	YES	YES	YES	NA	NA
5		Hand injury	YES	YES	YES	YES	YES
6		Excessive Urination	YES	YES	YES	YES	YES
7		Cold Symptoms	YES	YES	YES	NA	NA
8		Cold Symptoms and Backache	YES	YES	YES	NA	NA
9		Foot Fungus	YES	YES	YES	NA	NA
10		Foot Fungus	YES	YES	YES	NA	NA
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %	5 / 5 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
05/01/2018	10/17/2017	Central Arizona Florence Correctional Complex-East

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Phoenix ERO Field Office

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
574	574	0	1	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
8	7	1	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (520) 868- (b)(6); (b)(7)(C)	Phone Number: +1 (520) 868- (b)(6); (b)(7)(C)
Address: 1100 Bowling Road Florence, AZ. 85132	Address: 1100 Bowling Road Florence, AZ. 85132

Medical Care

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

CURRENT FINDINGS: No findings noted.

PREVIOUS FINDINGS (October 2017): One detainee's medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day. Per PBNDS 2008, "Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale." (Grievance System) (V) (C) (3) (2c)

Chronic Care

Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.

Total number with chronic conditions:	Total number with unstable chronic conditions:
42	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

POLICIES REVIEWED: Policy 13-06 "Chronic Care and Disease Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	8

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

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Description of deficiencies:

POLICIES REVIEWED: Policy 13-46 "Hunger Strikes" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	41

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-03 "Advance Directives Living Will-Durable Power of Attorney for Health Care"

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted. There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on May 1-3, 2018. The audit consisted of a review of 51 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees.

FACILITY DATA:
Central Arizona Florence Correctional Complex-East (CAFCC-East) is a non-dedicated contracted detention facility located in Florence, AZ. It is owned and operated by CoreCivic. The facility houses a combination of US Marshal (USM) inmates, ICE detainees (ICE), Material Witnesses (MWIT), Mesa inmates (MESA), and Bureau of Prison (BOP) inmates.

POPULATION CHARACTERISTICS:
Maximum Population- 5003 (606 ICE, 4037 USM, 160 MWIT, 160 MESA, and 40 BOP).
Current Population- 4192 (574 ICE, 3381 USM, 122 MWIT, 107 MESA, and 8 BOP).

ACCREDITATIONS/INSPECTIONS:
-National Commission on Correctional Health Care (NCCHC) completed an audit on March 8, 2018 and found no deficiencies.
-ICE Office of Detention Oversite (ODO) completed an audit on Sept 12, 2017 and found one deficiency. The Clinical Medical Authority was not signing off on intakes within 12 hours of intake. CAFCC-East completed a corrective action plan (CAP) to address the deficiency. All intakes were reviewed and signed off within 24 hours or next business day by the Clinical Medical Authority on this FMC site visit as per PBNDS 2008 standards.
-The Nakamoto Group completed an audit of the facility on August 22, 2017 and found two deficiencies. TB screening was not being done within 12 hours of arrival, and the Clinical Medical Authority was not signing off on intakes within 12 hours of intake. CAFCC-East completed a corrective action plan (CAP) to address the deficiencies. TB screening was completed within 12 hours on all charts reviewed on this site visit. All intakes were reviewed and signed off within 24 hours or next business day by the Clinical Medical Authority on this FMC site visit as per PBNDS 2008 standards.
-The American Correctional Association (ACA) completed an audit on April 6, 2016 and found no deficiencies.

MEDICAL CLINIC/INFIRMARY:

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The main medical unit has three exam rooms, a dental clinic, nurses station, and a laboratory room for specimen collection. A locked pharmacy and locked medical records/supply room are located in main medical (facility utilizes electronic medical records). There are two negative pressure isolation rooms. There are three observation rooms, one of which is designated as a suicide observation room. Emergency equipment is located in the main medical department to include an emergency response bag, gurney, AED, portable suction, oxygen tank, and two electrocardiogram machines. Emergency equipment is checked twice a day by the nursing staff.

CREDENTIALS:
Reviewed (b)(7)(E) There were no issues with the 11 files reviewed. Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.

CURRENT MEDICAL STAFFING:
(b)(7)(E)

Deficiencies for Areas Evaluated

PBNDS 2008 DEFICIENCIES: - None

Quality of care findings:
-Continuity of Medication: In 2 of 10 (20%) cases, the period of time from order to first dose exceeded 24 hours.
-Diabetes: Two of nine (22%) did not have a blood sugar measured at intake.
-HIV: One of one (100%) was not seen by an HIV or ID specialist within 30 days of identification. One of one (100%) did not have a CD4 and viral load completed within 14 days of arrival to the facility.
-Hypertension: One of nine (11%) did not have a documented blood pressure on the medical intake.
-Asthma: One of six (17%) did not have a peak flow measurement completed during the physical exam.

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Suicide Screening

POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

CAFCC-East performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.
CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

In the past 12 months there have been 41 detainees on suicide watch. Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) suicidal patients were evaluated by the physician within 24 hours of identification.
-10 of 10 (100%) were evaluated by a qualified mental health professional every day.
-10 of 10 (100%) were monitored by a detention officer who documented every 15 minutes.

-In the ten charts reviewed, there was no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Health Assessment

POLICIES REVIEWED: Policy 13-40 "Health Appraisals" is compliant with ICE PBNDS 2008.

20 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-20 of 20 (100%) had a transfer summary with a chest x-ray report.
-2 of 2 (100%) were referred for evaluation after having a positive screen for mental illness or suicide risk.
-20 of 20 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-20 of 20 (100%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, all health appraisals are completed by either the NP or the physician.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy 13-80 "Sick Call" is compliant with PBNDS 2008.

According to the HSA, the sick call process is initiated by a detainee filling out a paper sick call request. Sick call is done seven days a week. A nurse picks up sick call requests daily, and they are addressed within 24 hours.

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool used to evaluate this area.
-10 of 10 (100%) charts reviewed had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and vital signs were documented. Three detainees required a referral to MD/MLP with in 24 hours and had an MD/NP/DMD documented assessment and plan.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

POLICIES REVIEWED: Policy 13-34 "Medical Emergency Response" is compliant with PBNDS 2008.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-10 of 10 (100%) had an outbound progress note.
-10 of 10 (100%) showed no evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-10 of 10 (100%) had discharge documentation from the hospital and an inbound assessment. There was no evidence to suggest that earlier intervention could have prevented deterioration to the point of needing outside emergency care.

PREVIOUS FINDING (October 2017): No findings noted.

CURRENT FINDING: No findings noted.

Medication Administration Practices

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008.

-CAFCC-East currently uses electronic medication administration records. During direct observation, there was no evidence that staff was pre-pouring medication. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly.

Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-Approximately 10% of the MARs reviewed contained blanks, consecutive refusals, or no shows. In every case a refusal form was completed.
-No MARs were found pending to be filed. CAFCC-East uses electronic medication administration records (Allscripts).
-Approximately 40% of patients are on self-administered medication ordered by a provider.
-Over the Counter (OTC) medications are provided by both medical and can be purchased at the commissary.
-0 of 10 MARs reviewed had three consecutive days of refusals or 3 consecutive doses and or 4 or more doses in a week documented.

PREVIOUS FINDING (October 2017): One detainee refused 30 consecutive days of medication and the prescribing clinician was not notified.

CURRENT FINDING: No findings noted.

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Continuity of Medication

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008.

When a detainee arrives to the facility with chronic medications, the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) charts showed that medications were ordered in less than 24 hours from completion of the intake.
-In 8 of 10 (80%) cases, the period of time from order to first dose was less than 24 hours. In the other two cases, both detainees received their first dose two days after ordered.

PREVIOUS FINDINGS (October 2017): In 3 of 10 (30%) cases, the period of time from order to first dose exceeded 24 hours.

CURRENT FINDINGS: In 2 of 10 (20%) cases, the period of time from order to first dose exceeded 24 hours. According to the HSA, the medications on these two detainees are not kept in stock and had to be shipped to the facility from their pharmacy in Indiana. Both detainees received their first dose two days after ordered. The two medications were Accyclovir and Atripla.

Mental Health Screen

POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008.

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide. CAFCC-East mental health providers also perform a comprehensive mental health evaluation on all new detainees within 7 days of booking into the facility.

Ten charts selected from the mental health caseload were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy 13-58 "Medical Records" is compliant with PBNDS 2008.

CAFCC-East uses an electronic medical record system (Allscripts).

Ten charts were reviewed using the IHSC Quality of Care Audit Tool. No areas of concern were noted during reviews of medical records, facility processes, procedures and policy.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Pregnant Women

N/A. Females are not housed at the facility.

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Dental Care

POLICIES REVIEWED: Policy 13-13 "Dental Care" is compliant with PBNDS 2008.

CAFCC-East has a full-time dentist and a full-time dental assistant. All detainees receive a dental screening by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request. The dentist evaluates the patient the following working day and decides if treatment is appropriate. The treatment is then scheduled.

Ten charts selected from the sick call log were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) were screened for symptoms during the intake process.
-10 of 10 (100%) were evaluated by a qualified health professional within 48 hours of the request.
-10 of 10 (100%) dental notes reviewed described findings, diagnosis, treatment, and plans.
-4 of 4 (100%) were scheduled for follow-up treatment as recommended.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" is compliant with PBNDS 2008.

None of the charts reviewed contained STAT or acute lab work orders; however, ten contained completed routine lab work. The IHSC Quality of Care Tool was used to evaluate these records.
-10 of 10 (100%) had lab work collected within one business day of the ordered date. All lab orders reviewed were considered routine, and all were ordered during the initial chronic care appointment.
-10 of 10 (100%) were routine labs and had a report back and acknowledged within seven days.
-10 of 10 (100%) had clinical acknowledgment and an appropriate clinical response.
-9 of 9 (100%) patient charts reviewed had documentation that the patient was advised of the lab results.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" and Policy 13-64 "Off Site Care and Consultations" is compliant with PBNDS 2008.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-10 of 10 (100%) had a documented time urgency included on the order for specialty care or diagnostic services. Eight of the ten had the appointment accomplished within 30 days of the order.
-10 of 10 (100%) had the appointment accomplished within 45 days of the order.
-2 of 2 (100%) were re-evaluated for deterioration every 30 days until off-site service was completed.
-10 of 10 (100%) had clinician acknowledgment for the specialist's report in the medical record within 7 days of the date the service was performed.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008.

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake screening. Detainees who screen positive are referred to a mental health provider and are generally seen the next day. CAFCC-East mental health staff also perform a comprehensive mental health evaluation on all new detainees within 7 days of booking into the facility.

Ten records out of the active mental health case load were reviewed using the IHSC Quality of Care tool.
-10 of 10 (100%) had a clinical assessment, treatment, and follow-up plan documented.
-10 of 10 (100%) patient reviewed had a treatment plan updated at a minimum of every 90 days.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Treatment of Disability

POLICIES REVIEWED: Policy 13-82 "Special needs Treatment Plans" is compliant with PBNDS 2008.

At the time of this audit, there were four detainees documented to have a disability. The records were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-4 of 4 (100%) had the disability prominently displayed in the medical file.

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-4 of 4 (100%) were assessed for assistance of activities of daily living (ADL) upon identification of disability and had appropriate accommodation orders entered.
-1 of 1 (100%) had ADL assistance provided.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Complaints and Grievances

POLICIES REVIEWED: Policy 13-08 "Complaint Resolution" and Policy 14-05 "Inmate-Resident Grievance Procedures"

According to the Health Service Administrator at CAFCC-East, all dorms have access to grievance forms and a locked drop box labeled for this purpose. The sick call nurse picks them up daily. All medical grievances are then given to the Clinical Supervisor, who is an RN, and reviewed. The Clinical Supervisor is then responsible for answering all medical grievances within 5 business days. After they are appropriately addressed, they are scanned into the electronic health records. A grievance log is maintained to evaluate for trends in grievances.

The IHSC Quality of Care Audit Tool was used to evaluate this area.
-A total of 43 grievances were submitted over the past 3 months.
-43 of 43 (100%) grievances were addressed within 5 working days of receipt.
-2 of 43 were related to denial or refusal of specific request for care.
-11 of 43 were related to delays in care.
-2 of 43 were related to competency/professional skillset of medical staff.
-28 of 43 were related to receiving or making changes to medications.

PREVIOUS FINDINGS (October 2017): One medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day.

CURRENT FINDINGS: No findings noted.

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Diabetes

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Nine diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage diabetes.
-7 of 9 (77%) had a blood sugar measured at intake.
-9 of 9 (100%) were seen for chronic care by a medical provider within 14 days.
-7 of 7 (100%) had a baseline HgbA1C performed within the first 30 days.
-7 of 7 (100%) had lipids measured within one year.
-7 of 7 (100%) were followed at least every 90 days with appropriate vital signs.
-1 of 1 (100%) had aspirin prescribed when indicated.
-7 of 7 (100%) had a degree of control (goal HgbA1C<8.0) documented.
-4 of 4 (100%) had a strategy to attain diabetes control documented when HgbA1C was above goal.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: Two of nine (22%) did not have a blood sugar measured at intake.

Human Immunodeficiency Virus (HIV)

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

At the time of this audit, CAFCC-East had only one ICE detainee documented as having HIV. He was released from ICE custody 41 days after arrival to the facility. The record was reviewed using the IHSC Quality of Care Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage HIV.
-HIV was identified by patient interview during the medical intake.
-Detainee was scheduled to see an HIV specialist, but was released from the facility five days before the appointment.
-A CD4 and viral load were ordered but was not drawn before the detainee was released from the facility.
-Antiretroviral treatment was considered and documented.
-A chest x-ray was completed the same day that he was identified with HIV.

PREVIOUS FINDINGS (October 2017): One detainee was not seen by an HIV or ID specialist within 30 days of identification.

CURRENT FINDING: One detainee was not seen by an HIV or ID specialist within 30 days of identification. He was scheduled for the appointment, but was released from the facility five days before the appointment. A CD4 and viral load were ordered but not completed within 14 days of arrival to the facility.

Hypertension

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Nine charts of hypertensive patients were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage hypertension.
-8 of 9 (88%) had a documented blood pressure on the medical intake.
-9 of 9 (100%) patients were seen by a medical provider within the first 14 days of arrival at the facility.
-8 of 8 (100%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90. In all eight (100%) medical records there was documentation that the nurse called and received a treatment plan from the provider which included medication and blood pressure monitoring.
-In 8 of 8 (100%) cases, it appeared that a chronic disease guideline for HTN, which included obtaining baseline lab work, was followed.

PREVIOUS FINDINGS (October 2017): No findings noted.

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CURRENT FINDINGS: One of nine (11%) did not have a documented blood pressure on the medical intake.

Asthma

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Six charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area. CAFCC-East follows NCCHC clinical practice guidelines to manage asthma.
-6 of 6 (100%) were seen for chronic care by a medical provider within 14 days of illness identification.
-5 of 6 (83%) had a peak flow measurement completed during the physical exam.
-6 of 6 (100%) had a peak flow measurement completed at the chronic care visit.
-6 of 6 (100%) followed a chronic disease guideline which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: One of six (17%) did not have a peak flow measurement completed during the physical exam.

Seizure Disorder

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Only one chart of a seizure patient was reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area. He was released from the facility after 10 days.
-1 of 1 (100%) had an appropriate neurological assessment completed at the initial physical exam.
-1 of 1 (100%) was seen by a medical provider within 14 days of illness identification.
-1 of 1 (100%) had an established treatment plan.
-1 of 1 (100%) had orders for a bottom bunk.

PREVIOUS FINDINGS (October 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

The HSA, Clinical Supervisor, Program Manager and the facility Warden were notified of all findings/deficiencies during a close-out interview. The Florence Assistant Field Office Director (AFOD) was given a summary of findings via telephone and email.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (602) 766- (b)(6); (b)(7)(C)	Date Prepared: 05/09/2018
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360- (b)(6); (b)(7)(C)	Date Reviewed: 07/24/2018
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732- (b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional FMC
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 07/24/2018
Recommendations: (b)(5)	

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
10/17/2017	04/26/2017	Central Arizona Florence Correctional Complex-East

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Phoenix ERO Field Office

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
570	570	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
9	8	1	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (520) 868-(b)(6); (b)(7)(C)	Phone Number: +1 (520) 868-(b)(6); (b)(7)(C)
Address: 1100 Bowling Road Florence, AZ. 85132	Address: 1100 Bowling Road Florence, AZ. 85132

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

CURRENT FINDINGS: One 2008 PBNDS deficiency
-One detainee's medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day. Per PBNDS 2008, "Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale." (Grievance System) (V) (C) (3) (2c)

PREVIOUS FINDINGS (April 2017): One 2008 PBNDS deficiency.
-Two detainees health assessments were not completed within 14 days of their arrival to the facility (Medical Care) (V) (J).

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
44	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

POLICIES REVIEWED: Policy 13-06 "Chronic Care and Disease Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	1

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

POLICIES REVIEWED: Policy 13-46 "Hunger Strikes" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted. FCC has had one detainee on hunger strike in the past year.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	55

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-03 "Advance Directives Living Will-Durable Power of Attorney for Health Care"

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted. There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on October 17-20, 2017. The audit consisted of a review of 61 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees.

FACILITY DATA:
Central Arizona Florence Correctional Complex-East (CAFCC-East) is a non-dedicated contracted detention facility located in Florence, AZ. It is owned and operated by CoreCivic. The facility houses a combination of US Marshal (USM) inmates, ICE detainees (ICE), Material Witnesses (MWIT), Mesa inmates (MESA), and Bureau of Prison (BOP) inmates.

POPULATION CHARACTERISTICS:
Maximum Population- 1966 (686 ICE, 960 USM, 80 MWIT, 160 MESA, and 80 BOP).
Current Population- 1599 (589 ICE, 812 USM, 43 MWIT, 111 MESA, and 44 BOP).

ACCREDITATIONS/INSPECTIONS:
-ICE Office of Detention Oversite (ODO) completed an audit on Sept 12, 2017 and found one deficiency. The Clinical Medical Authority was not signing off on intakes within 12 hours of intake. CAFCC-East completed a corrective action plan (CAP) to address the deficiency. All intakes were reviewed and signed off within 24 hours or next business day by the Clinical Medical Authority on this FMC site visit as per PBNDS 2008 standards.
-The Nakamoto Group completed an audit of the facility on August 22, 2017 and found two deficiencies. TB screening was not being done within 12 hours of arrival, and the Clinical Medical Authority was not signing off on intakes within 12 hours of intake. CAFCC-East completed a corrective action plan (CAP) to address the deficiencies. TB screening was completed within 12 hours on all charts reviewed on this site visit. All intakes were reviewed and signed off within 24 hours or next business day by the Clinical Medical Authority on this FMC site visit as per PBNDS 2008 standards.
-The American Correctional Association (ACA) completed an audit on April 6, 2016 and found no deficiencies.
-National Commission on Correctional Health Care (NCCHC) completed an audit on February 23, 2016 and found no deficiencies.

MEDICAL CLINIC/INFIRMARY:
The main medical unit has three exam rooms, a dental clinic, nurses station, and a laboratory

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room for specimen collection. A locked pharmacy and a locked medical records/supply room are located in main medical (facility utilizes electronic medical records). There are two negative pressure isolation rooms. There are three observation rooms, one of which is designated as a suicide observation room. Emergency equipment is located in the main medical department to include an emergency response bag, gurney, AED, portable suction, oxygen tank, and two eloctrocardiogram machines. Emergency equipment is checked twice a day by the nursing staff.

(b)(7)(E)

CREDENTIALS:
Reviewed (b)(7)(E) staff licensing credentials. There were no issues with the files reviewed. Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.

CURRENT MEDICAL STAFFING:

(b)(7)(E)

Deficiencies for Areas Evaluated

PBNDS 2008 DEFICIENCIES: -One detainee's medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day.

Quality of care findings:
-Medication Administration Practices: One detainee refused 30 consecutive days of medication and the prescribing clinician was not notified.
-Continuity of Medication: In 3 of 10 (30%) cases, the period of time from order to first dose exceeded 24 hours.
-HIV: One detainee was not seen by an HIV or ID specialist within 30 days of identification.

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Suicide Screening

POLICIES REVIEWED: Policy 13-84 "Suicide Management"

CAFCC-East performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.
CAFCC-East also performs a comprehensive mental health evaluation by a mental health provider within 7 days of booking into the facility for all new detainees.

In the past 12 months there have been 55 detainees on suicide watch. Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) suicidal patients were evaluated by the physician within 24 hours of identification.
-10 of 10 (100%) were evaluated by a qualified mental health professional every day.
-10 of 10 (100%) were monitored by a detention officer who documented every 15 minutes.

-In the ten charts reviewed, there was no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Health Assessment

POLICIES REVIEWED: Policy 13-40 "Health Appraisals"

20 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-20 of 20 (100%) had a transfer summary with a chest x-ray report.
-2 of 2 (100%) were referred for evaluation after having a positive screen for mental illness or suicide risk.
-11 of 11 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-20 of 20 (100%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, all health appraisals are completed by either the NP or the physician.

PREVIOUS FINDINGS (April 2017): 2 of 20 (10%) health appraisals reviewed were done greater than 14 days from arrival.

CURRENT FINDINGS: No findings noted.

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy 13-80 "Sick Call"

According to the HSA, the sick call process is initiated by a detainee filling out a paper sick call request. Sick call is done seven days a week. A nurse picks up sick call requests daily, and they are addressed within 24 hours.

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-10 of 10 (100%) charts reviewed had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and vital signs were documented. Five detainees required a referral to MD/MLP with in 24 hours and had an MD/NP/DMD documented assessment and plan.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

POLICIES REVIEWED: Policy 13-34 "Medical Emergency Response"

In the past six months, eight detainees have been sent to an emergency department. All eight charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-8 of 8 (100%) had an outbound progress note.
-8 of 8 (100%) showed no evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-8 of 8 (100%) had discharge documentation from the hospital and an inbound assessment.

PREVIOUS FINDING (April 2017): No findings noted.

CURRENT FINDING: No findings noted.

Medication Administration Practices

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals"

-CAFCC-East currently uses electronic medication administration records. During direct observation, there was no evidence that staff was pre-pouring medication. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly.

Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-10% of the MARs reviewed contained blanks, consecutive refusals, or no shows. In every case a refusal form was completed.
-No MARs were found pending to be filed. FCC uses electronic medication administration records (Allscripts).
-Approximately 45% of patients are on self-administered medication ordered by a provider.
-Over the Counter (OTC) medications are provided by medical and can be purchased in the commissary.
-1 of 10 MARs reviewed had three consecutive days of refusals or 3 consecutive doses and or 4 or more doses in a week documented. There was no documentation in the medical record that the prescribing clinician was notified of consecutive refusals; therefore, there was no response from the clinician.

PREVIOUS FINDING (April 2017): No findings noted.

CURRENT FINDING: One detainee refused 30 consecutive days of medication, and the prescribing clinician was not notified. The medication missed was Metformin. According to the HSA, CAFCC-East policy on notifying the prescribing clinician of consecutive refusals does not include this particular type of medication. CAFCC-East policy on missed doses states, "The following will be monitored for compliance: anticonvulsants, antipsychotics, antidepressants, Isoniazid or other anti-tuberculosis medications, anticoagulants, Lanoxin, HIV and HCV medications, and any medications specifically prescribed by the LIP for compliance monitoring. If an inmate/resident patient does not pick up the above medications for three consecutive medication doses or a pattern of missed doses, it is identified and documented in the medical record. Once identified, the inmate/resident patient should be referred to a licensed nurse or LIP for discussion on non-compliance to address urgent incidents of missing medications."

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Continuity of Medication

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals"

When a detainee arrives to the facility with chronic medications, the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) charts showed that medications were ordered in less than 24 hours from completion of the intake.
-In 7 of 10 (70%) cases, the period of time from order to first dose was less than 24 hours.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: In 3 of 10 (30%) cases, the period of time from order to first dose exceeded 24 hours. According to the HSA, the intake nurses failed to properly document that the medications that arrived with the detainee were given as KOP after being ordered by the clinician.

Mental Health Screen

POLICIES REVIEWED: Policy 13-61 "Mental Health Services"

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

Ten charts selected from the mental health caseload were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy 13-58 "Medical Records" is compliant with PBNDS 2008.

CAFCC-East uses an electronic medical record system (Allscripts).

Ten charts were reviewed using the IHSC Quality of Care Audit Tool. No areas of concern noted during reviews of medical records, facility processes, procedures and policy.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Pregnant Women

N/A. Females are not housed at the facility.

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Dental Care

POLICIES REVIEWED: Policy 13-13 "Dental Care"

CAFCC-East has a full-time dentist and a full-time dental assistant. All detainees receive a dental screening by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request. The dentist evaluates the patient the following working day and decides if treatment is appropriate. The treatment is then scheduled.

Ten charts selected from the sick call log were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) were screened for symptoms during the intake process.
-10 of 10 (100%) were evaluated by a qualified health professional within 48 hours of the request.
-10 of 10 (100%) dental notes reviewed described findings, diagnosis, treatment, and plans.
-10 of 10 (100%) were scheduled for follow-up treatment as recommended.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services"

None of the charts reviewed contained STAT or acute lab work orders; however, ten contained completed routine lab work. The IHSC Quality of Care Tool was used to evaluate these records.
-10 of 10 (100%) had lab work collected within one business day of the ordered date. All lab orders reviewed were considered routine and all were ordered during the initial chronic care appointment.
-10 of 10 (100%) were routine labs and had a report back and acknowledged within seven days.
-10 of 10 (100%) had clinical acknowledgment and an appropriate clinical response.
-10 of 10 (100%) patient charts reviewed had documentation that the patient was advised of the lab results.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" and Policy 13-64 "Off Site Care and Consultations"

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-10 of 10 (100%) had a documented time urgency included on the order for specialty care or diagnostic services. All ten had the appointment accomplished within 30 days of the order.
-10 of 10 (100%) had the appointment accomplished within 45 days of the order.
-10 of 10 (100%) had clinician acknowledgment for the specialist's report in the medical record within 7 days of the date the service was performed.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy 13-61 "Mental Health Services"

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake screening. Detainees who screen positive are referred to a mental health provider and are generally seen on the next day. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

Ten records out of the active mental health case load were reviewed using the IHSC Quality of Care tool.
-10 of 10 (100%) had a clinical assessment, treatment, and follow-up plan documented.
-3 of 3 (100%) patient reviewed had a treatment plan updated at a minimum of every 90 days.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Treatment of Disability

POLICIES REVIEWED: Policy 13-82 "Special needs Treatment Plans"

At the time of this audit, there were three detainees documented to have a disability. The records were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-3 of 3 (100%) had the disability prominently displayed in the medical file.
-3 of 3 (100%) was assessed for assistance of activities of daily living (ADL) upon identification of disability and appropriate accommodation orders were entered.
PREVIOUS FINDINGS (April 2017): No findings noted.

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CURRENT FINDINGS: No findings noted.

Complaints and Grievances

POLICIES REVIEWED: Policy 13-08 "Complaint Resolution" and Policy 14-05 "Inmate-Resident Grievance Procedures"

According to the Health Service Administrator at CAFCC-East, all dorms have access to grievance forms and a locked drop box labeled for this purpose. The sick call nurse picks them up daily. All medical grievances are then given to the Provider Coordinator, who is an LPN, and reviewed. The Provider Coordinator is then responsible for answering all medical grievances within 5 business days. After they are appropriately addressed, they are scanned into the electronic health records. A grievance log is maintained to evaluate for trends in grievances.

The IHSC Quality of Care Audit Tool was used to evaluate this area.
-A total of 19 grievances were submitted over the past 3 months.
-18 of 19 (95%) grievances were addressed within 5 working days of receipt.
-2 of 19 were related to availability of care.
-3 of 19 were related to denial or refusal of specific request for care.
-5 of 19 were related to delays in care.
-1 of 19 was related to attitude, demeanor or conduct of staff.
-8 of 19 were related to receiving or making changes to medications.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: One detainee's medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day.

AMERICAN OVERSIGHT

Diabetes

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Nine diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage diabetes.
-9 of 9 (100%) had a blood sugar measured at intake.
-9 of 9 (100%) were seen for chronic care by a medical provider within 14 days.
-9 of 9 (100%) had a baseline HgbA1C performed within the first 30 days.
-4 of 4 (100%) had lipids measured within one year.
-3 of 3 (100%) had aspirin prescribed when indicated.
-9 of 9 (100%) had a degree of control (goal HgbA1C<8.0) documented.
-6 of 6 (100%) had a strategy to attain diabetes control documented when HgbA1C was above goal.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Human Immunodeficiency Virus (HIV)

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

At the time of this audit, CAFCC-East had only one ICE detainee documented as having HIV. He was transferred to USM custody 49 days after arrival to the facility. The record was reviewed using the IHSC Quality of Care Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage HIV.
-HIV was identified by the available medical records upon transfer to the facility.
-Detainee was not seen by an HIV or ID specialist within 30 days of identification.
-Antiretroviral treatment was considered and documented.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDING: One detainee was not seen by an HIV or ID specialist within 30 days of identification.

Hypertension

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Nine charts of hypertensive patients were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose. CAFCC-East follows NCCHC clinical practice guidelines to manage hypertension.
-9 of 9 (100%) had a documented blood pressure on the medical intake.
-9 of 9 (100%) patients were seen by a medical provider within the first 14 days of arrival at the facility.
-6 of 6 (100%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90. In all six (100%) medical records there was documentation that the nurse called and received a treatment plan from the provider which included medication and blood pressure monitoring.
-In 9 of 9 (100%) cases, it appeared that a chronic disease guideline for HTN, which included obtaining baseline lab work, was followed.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Asthma

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Eight charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area. CAFCC-East follows NCCHC clinical practice guidelines to manage asthma.

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-6 of 6 (100%) were seen for chronic care by a medical provider within 14 days of illness identification.
-8 of 8 (100%) had a peak flow measurement completed during the physical exam.
-6 of 6 (100%) had a peak flow measurement completed at the chronic care visit.
-6 of 6 (100%) followed a chronic disease guideline which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

Seizure Disorder

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management"

Three charts of seizure patients were reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-3 of 3 (100%) had an appropriate neurological assessment completed at the initial physical exam.
-3 of 3 (100%) were seen by a medical provider within 14 days of illness identification.
-1 of 1 (100%) had serum drug levels performed and acknowledged at least every 3 months until stable.
-3 of 3 (100%) had an established treatment plan.
-3 of 3 (100%) had orders for a bottom bunk.

PREVIOUS FINDINGS (April 2017): No findings noted.

CURRENT FINDINGS: No findings noted.

AMERICAN OVERSIGHT

Recommendations

(b)(5)

Facility Actions

The HSA, Clinical Supervisor, Program Manager and the facility Warden were notified of all findings/deficiencies during a close-out interview. The Florence Assistant Field Office Director (AFOD) was given a summary of findings via telephone and email.

Additional Comments

AMERICAN OVERSIGHT

End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 210-(b)(6); (b)(7)(C)	Date Prepared: 10/27/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 11/08/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 11/24/2017

Recommendations:

(b)(5)

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
05/07/2019	05/04/2018	Central Arizona Florence Correctional Complex-East

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	PHO ERO Field Office

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
467	467	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
2	1	1	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (520) 868-(b)(6); (b)(7)(C)	Phone Number: +1 (520) 868-(b)(6); (b)(7)(C)
Address: 1155 N. Pinal Parkway Florence, AZ 85132	Address: 1155 N. Pinal Parkway Florence, AZ 85132

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
PREVIOUS FINDINGS (May 2018): No findings noted.

CURRENT FINDINGS: Three of 20 (15%) detainees did not have a completed intake screening within 12 hours of booking into the facility. Per PBNDS 2008, "Initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function." (Medical Care) (V) (I) (1)

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
33	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-06 "Chronic Care and Disease Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (May 2018): No findings noted.

CURRENT FINDINGS: No findings noted.

Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	10

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

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Description of deficiencies:

POLICIES REVIEWED: Policy 13-46 "Hunger Strikes" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (May 2018): No findings noted.

CURRENT FINDINGS: No findings noted.

AMERICAN OVERSIGHT

Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
0	51

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (May 2018): No findings noted.

CURRENT FINDINGS: No findings noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (May 2018): No findings noted.

CURRENT FINDINGS: No findings noted.

Other Observations

This FMC site visit was conducted on May 7-10, 2019. The audit consisted of a review of 48 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees.

FACILITY DATA:
Central Arizona Florence Correctional Complex-East (CAFCC-East) is a non-dedicated contracted detention facility located in Florence, AZ. It is owned and operated by CoreCivic. The facility houses a combination of US Marshal (USM) inmates, ICE detainees (ICE), Mesa inmates (MESA), and Bureau of Prison (BOP) inmates.

POPULATION CHARACTERISTICS:
Maximum Population- 5013 (500 ICE, 4378 USM, 120 MESA, and 15 BOP).
Current Population- 4454 (467 ICE, 3896 USM, 80 MESA, and 11 BOP).

ACCREDITATIONS/INSPECTIONS:
-The American Correctional Association (ACA) completed an audit on March 25, 2019 and found no deficiencies.
-The Nakamoto Group completed an audit of the facility on August 27, 2018 and found no deficiencies.
-National Commission on Correctional Health Care (NCCHC) completed an audit on April 24, 2018 and found no deficiencies. CAFCC-East received Facility of the Year Award from NCCHC for 2018.

MEDICAL CLINIC/INFIRMARY:
The main medical unit has three exam rooms, a dental clinic, nurses station, and a laboratory room for specimen collection. A locked pharmacy and a locked medical records/supply room are located in main medical (facility utilizes electronic medical records). There are two negative pressure isolation rooms. There are three observation rooms, one of which is designated as a suicide observation room. Emergency equipment is located in the main medical department to include an emergency response bag, gurney, AED, portable suction, oxygen tank, and two electrocardiogram machines. Emergency equipment is checked twice a day by the nursing staff.

CREDENTIALS:
Reviewed all of the staff licensing credentials. There were no issues with the files

AMERICAN OVERSIGHT

reviewed. Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.

Deficiencies for Areas Evaluated

PBNDS 2008 DEFICIENCIES: 3 of 20 (15%) detainees did not have a completed intake screening within 12 hours of booking into the facility. Per PBNDS 2008, "Initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function." (Medical Care) (V) (I) (1)

Quality of care findings:
-Asthma: Five of five (100%) did not have a peak flow measurement completed during the physical exam.
-Diabetes: One of nine (11%) did not have a blood sugar measured at intake.
-HIV: Two of two (100%) were not seen by an HIV or ID specialist within 30 days of identification.
-Continuity of Medication: In 1 of 10 (10%) cases, the period of time from order to first dose exceeded 24 hours.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES

Suicide Screening

See QMC toolkit.

Health Assessment

See QMC toolkit.

Urgent Care (Sick Call)

See QMC toolkit.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

See QMC toolkit.

Medication Administration Practices

See QMC toolkit.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES (continued)

Continuity of Medication

See QMC toolkit.

Mental Health Screen

See QMC toolkit.

Medical Recordkeeping Practices

See QMC toolkit.

Pregnant Women

N/A. Females are not housed at the facility.

Dental Care

See QMC toolkit.

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Acute Laboratory Testing

See QMC toolkit.

Diagnostic Services and Specialty Care Access

See QMC toolkit.

Mental Health Treatment Planning

See QMC toolkit.

Treatment of Disability

See QMC toolkit.

Complaints and Grievances

See QMC toolkit.

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ASSESSMENT OF QUALITY OF HEALTH SERVICES
CHRONIC DISEASES

Diabetes

See QMC toolkit.

Human Immunodeficiency Virus (HIV)

See QMC toolkit.

Hypertension

See QMC toolkit.

Asthma

See QMC toolkit.

Seizure Disorder

See QMC toolkit.

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Recommendations

(b)(5)

Facility Actions

The HSA, Clinical Supervisor, Program Manager, Assistant Warden, and the facility Warden were notified of all findings/deficiencies during a close-out interview. The Florence Assistant Field Office Director (AFOD) was given a summary of findings via telephone and email.

Additional Comments

AMERICAN OVERSIGHT

End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (602) 766-(b)(6); (b)(7)(C)	Date Prepared: 05/14/2019
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 06/10/2019
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional Field Medical Coordinator
Email: (b)(6); (b)(7)(C)	Phone Number:
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 06/19/2019

Recommendations:

(b)(5)

AMERICAN OVERSIGHT

CHRONIC DISEASE – ASTHMA (MODERATE AND SEVERE)

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random.

1 Does the facility follow a particular clinical practice guideline to manage asthma? YES
If so, what is the guideline? NCCHC

Item # Measure

1 Was patient seen in CCC by mid-level provider or physician within 14** days of illness identification?
2 Was a peak flow completed at the initial physical exam?
3 Was a peak flow completed at the CC visit or within the last 3 months?
4 *Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	YES	YES
4		YES	YES	YES	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		NA	NA	NA	NA
8		NA	NA	NA	NA
9		NA	NA	NA	NA
10		NA	NA	NA	NA
	Total	6 / 6 100 %	6 / 6 100 %	6 / 6 100 %	6 / 6 100 %

KEY: N/A = Not applicable
*This criterion may require physician review. Please note in report if physician input was utilized.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Chronic Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf
National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3. https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Peak Expiratory Flow Rates, (Sept, 2016). http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm

AMERICAN OVERSIGHT

CHRONIC DISEASE – SEIZURE DISORDER

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with seizure disorder chosen at random.
What clinical practice guideline does the facility use to manage seizures? NCCHC

Item #	Measure
1	Was an appropriate neurological history completed at the initial physical examination?
2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification*?
3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?
4	Was a treatment plan established?
5	Are there orders for a bottom bunk?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES
2		NA	NA	NA	NA	NA
3		NA	NA	NA	NA	NA
4		NA	NA	NA	NA	NA
5		NA	NA	NA	NA	NA
6		NA	NA	NA	NA	NA
7		NA	NA	NA	NA	NA
8		NA	NA	NA	NA	NA
9		NA	NA	NA	NA	NA
10		NA	NA	NA	NA	NA
	Total	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002863

COMPLAINTS AND GRIEVANCES

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess use of medical complaint and grievance data as part of the quality management program.

Source: Facility grievance logs.

Sample: Facility's periodic grievance analyses, with underlying data (grievances and responses).

Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? Please answer yes or no NO If yes, please address in the comments section whether and how the facility uses this information to implement change.

How many medical grievances were submitted over the past 3 months? 7

What percentage of this number were appropriately addressed within 5 working days of receipt? 100 %

Item: 1 Of the grievances submitted over the past 3 months, enter the number of grievances in each category, i.e., availability of care, denial of request for care, etc.

2 Enter the A# for each grievance included in this category.

Grievance Type	1	2
Availability of care (sick call hours, etc.)		
Denial or refusal of specific request(s) for care	1	(b)(6); (b)(7)(C)
Delay(s) in care	4	
Competency/professional skillset of medical staff		
Attitude, demeanor or conduct of staff	2	
Other		
Total	7	

NCCHC 2014 J-A-06, J-A-11.

AMERICAN OVERSIGHT

CONTINUITY OF MEDICATION

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of medication, as ordered.

Source: Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).

Sample: Initially identify 10 patients from MARs, cross check date of first dose with order date in the medical record.

Item #	Measure
1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?
2	Period of time from order to first dose less than 24 hours?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		NO	NO
10		NO	NO
	Total	8 / 8 100 %	8 / 8 100 %

KEY: NA= not applicable

Reviewed February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002865

DENTAL CARE

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess compliance with detention standards and continuity of care.

Source: Dental sick call list or dental referral log

Sample: 10 records from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.

Item #	Measure
1	Was patient screened for symptoms during the intake process?
2	Was patient evaluated by a qualified health professional within 48 hours of request?
3	Do dental clinical notes describe findings, diagnosis, treatment and plans?
4	Was the patient scheduled for follow-up treatment as recommended?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	NA
3		YES	YES	YES	NA
4		YES	YES	YES	NA
5		YES	YES	YES	NA
6		YES	YES	YES	NA
7		YES	YES	YES	YES
8		YES	YES	YES	YES
9		YES	YES	YES	YES
10		YES	YES	YES	YES
	Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002866

CHRONIC DISEASE – DIABETES

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.
Source: Chronic disease registry or MARs.
Sample: 10 patients with diabetes chosen at random.
What clinical practice guideline does the facility use to manage diabetes? NCCHC

Item # Measure

1. Was blood sugar measured and recorded on intake?
2. Was patient seen for chronic care by a mid-level provider or physician within 14** days of illness identification?
3. Was a baseline HgbA1c performed within 30 days of intake or within past 3 months
4. Were lipids measured within one year?
5. Was patient followed at least every 90 days with appropriate vital signs?
6. Was aspirin prescribed, as clinically indicated?*
7. Was degree of control (goal GgbA1C<8.0) documented?
8. Was a strategy to attain diabetes control documented in HgbA3C was above goal?

	A #	1	2	3	4	5	6	7	8
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES	YES	NA	YES	YES
2		YES	YES	YES	NA	NA	NA	YES	NA
3		YES	YES	YES	YES	YES	YES	YES	YES
4		YES	YES	YES	YES	YES	YES	YES	YES
5		YES	YES	YES	YES	YES	NA	YES	YES
6		YES	YES	YES	YES	YES	NA	YES	NA
7		YES	YES	YES	YES	YES	YES	YES	NA
8		YES	YES	YES	YES	YES	NA	YES	YES
9		YES	YES	YES	YES	YES	NA	YES	YES
10		YES	YES	YES	YES	YES	NA	YES	NA
	Total	10/10 100%	10/10 100%	10/10 100%	9/9 100%	9/9 100%	3/3 10(%	10/10 100%	6/6 10C%

KEY: NA= not applicable

*Refer to User Guide for clinical indications.
**14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

AMERICAN OVERSIGHT

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Referrals log, medical records or MedPars

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Item # Measure

1. Was there a documented time urgency included on the order for specialty care or diagnostic services?
2. Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?
3. Was the patient re-evaluated for deterioration every 30 days until off-site service completed?
4. Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?

	A #	Clinic	1	2	3	4
1	(b)(6); (b)(7)(C)	Other	NO	YES	N/A	YES
2		Other	NO	YES	N/A	YES
3		Other	NO	YES	N/A	YES
4		Other	NO	YES	N/A	YES
5		Other	NO	YES	N/A	YES
6		Other	NO	YES	N/A	YES
7		Other	NO	YES	N/A	YES
8		Other	NO	YES	N/A	YES
9		Other	NO	YES	N/A	YES
10		Other	NO	YES	N/A	YES
		Total	0 / 10 0 %	10 / 10 100%	0 / 0 NaN%	10 / 10 100%

KEY: NA= not applicable

NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.

AMERICAN OVERSIGHT

EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE

DATE 04/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.

Source: Emergency Department (ED) logs.

Sample: Within the past 6 months, 10 patients sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.

Item # Measure

1. Is there an outbound progress note?
2. *Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the narrative portion of the report.
3. Is there discharge documentation from the hospital or ED in the chart?
4. Is there an inbound assessment?
5. Does the assessment reflect hospital findings and concurrence or deviation from hospital recommendations?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Altered Mental Status	YES	NO	YES	YES	YES
2		Seizures	YES	NO	YES	YES	YES
3		R/O Jaw Fracture	YES	NO	YES	YES	YES
4		Dizziness, Irregular HR	YES	NO	YES	YES	YES
5		Seizures	YES	NO	YES	YES	YES
6		R/O Dislocated Shoulder	YES	NO	YES	YES	YES
7			NO	NO	NO	NA	NA
8			NO	NO	NO	NA	NA
9			NO	NO	NO	NA	NA
10			NO	NO	NO	NA	NA
			6 / 6 100 %	0 / 0 NaN %	6 / 6 100 %	6 / 6 100 %	6 / 6 100 %

KEY: NA= not applicable

*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.

NCCHC 2014 J-E-12.

Revised February 2017

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002869

HEALTH ASSESSMENT

DATE 04/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?
2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4 Is there timely follow-up for significant findings of acute and chronic conditions?*
5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	NA	YES
5		YES	YES	NA	NA	YES
6		YES	YES	NA	NA	YES
7		YES	YES	NA	NA	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	NA	YES
10		YES	YES	NA	NA	YES
	Total	/ NaN %	/ NaN %	/ NaN %	/ NaN %	/ NaN %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

HEALTH ASSESSMENT

DATE 04/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.

Source: Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.

Sample: 20 medical records chosen at random.

Item # Measure

1 Initial screen complete within 12 hours of booking?
2 PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?
3 Are detainees who screen positive for mental illness or suicide risk referred for evaluation?
4 Is there timely follow-up for significant findings of acute and chronic conditions?*
5 Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 48 hours or addressed by phone and seen on the next business day.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	NA	NA	YES
2		YES	YES	NA	NA	YES
3		YES	YES	NA	NA	YES
4		YES	YES	NA	NA	NO
5		YES	YES	NA	NA	NO
6		YES	YES	NA	YES	YES
7		YES	YES	NA	NA	YES
8		YES	YES	NA	YES	YES
9		YES	YES	NA	YES	YES
10		YES	YES	NA	NA	YES
	Total	20 / 20 100 %	20 / 20 100 %	/ NaN %	4 / 4 100 %	18 / 20 90 %

KEY: NA= not applicable

NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25
*A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health

AMERICAN OVERSIGHT

CHRONIC DISEASE – HIV

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East (Transferred to USM after 7 da

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs for current detainees and those detained within the last 6 months.

Sample: 10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.
What clinical practice guideline does the facility use to manage HIV NCCHC

Item # Measure

1 How was HIV status identified? By laboratory, prior medical records or patient report?
2 Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?
3 Was patient seen by an HIV or ID specialist within 30 days of HIV identification?
4 Was antiretroviral treatment considered and documented?
5 Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?
6 Was a chest x-ray completed within 72 hours of problem identification, if not already done?

	A #	1	2	3	4	5	6
1	(b)(6); (b)(7)(C)	Medical Record	NA	NA	NA	NA	NA
2		Recent Lab	NA	NA	NA	NA	NA
3		Recent Lab	NA	NA	NA	NA	NA
4		Recent Lab	NA	NA	NA	NA	NA
5		Recent Lab	NA	NA	NA	NA	NA
6		Recent Lab	NA	NA	NA	NA	NA
7		Recent Lab	NA	NA	NA	NA	NA
8		Recent Lab	NA	NA	NA	NA	NA
9		Recent Lab	NA	NA	NA	NA	NA
10		Recent Lab	NA	NA	NA	NA	NA
	Total		0 / 0 NaN%	0 / 0 NaN%	0 / 0 NaN%	0 / 0 NaN%	0 / 0 NaN%

KEY: NA= not applicable

National Institutes of Health. Aids Info. https://aidsinfo.nih.gov/guidelines
University of California, San Francisco. HIV Clinical Consultation Center. http://nccc.ucsf.edu/
ACA 2004 4-ALDF-4C-18.

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002872

CHRONIC DISEASE – HYPERTENSION

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.

Source: Chronic disease registry or MARs.

Sample: 10 patients with hypertension chosen at random.

1 Does the facility follow a clinical practice guideline to manage hypertension? YES
2 If yes, what is the guideline? NCCHC

Item # Measure

1 Was a blood pressure reading noted at intake?
2 Was the patient seen by an MD/PA/NP within 14 days of illness identification*?
3 If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification*?
4 Was a chronic disease guideline, including baseline laboratory testing, followed?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	YES	YES
3		YES	YES	N/A	YES
4		YES	YES	N/A	YES
5		YES	YES	YES	YES
6		YES	YES	YES	YES
7		YES	YES	N/A	YES
8		YES	YES	YES	YES
9		YES	YES	N/A	YES
10		YES	YES	N/A	N/A
	Total	10 / 10 100 %	10 / 10 100 %	5 / 5 100 %	9 / 9 100 %

KEY: NA= not applicable

*14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.

NCCHC Guidelines for Disease Management, (2006). http://www.ncchc.org/filebin/Resources/Chronic-Disease-Management.pdf

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DHS-ICE-20-0618-A-002873

ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (FMC October 2017 Site Visit Follow-up)

Facility Name **Central Arizona Florence Correctional Complex-East**
Address (Street and Name) **1100 Bowling Road**
City, State and Zip Code **Florence, AZ 85132**
County **Pinal**
Date[s] of FMC Follow-up ***01/2018***
Complete and Return to ICE HQ No Later Than: **12/29/2017**

Facility Corrective Action Plan Assigned to: (b)(6); (b)(7)(C)
Date of Final Submission:

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Report produced on 11/15/2017

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC October 2017 Review) Central Arizona Florence Correctional Complex-East (PHO AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
One detainee's medical grievance was not addressed within five working days of receipt. It was appropriately addressed on the sixth working day. "Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale." (PBNDS 2008, Grievance System/V/C/3/2c)	(b)(5)	On August 24, 2017, procedures were implemented allowing detainees to submit medical grievances directly to medical department personnel designated to receive and response to medical grievances. Prior to implementing this change, grievances were required to be submitted to the Grievance Coordinator first and then submitted to medical. By putting a medical staff member in charge of ICE grievances it lessens the	8/24/17

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DHS-ICE-20-0618-A-002875

		amount of time before the grievance gets to a medical supervisor. The medical grievance coordinator also works in medical and has more access to the staff members who are doing the grievances to oversee the due date. It also keeps us HIPPA Compliant	
Quality of Care Finding: Medication Administration Practices: One detainee refused 30 consecutive days of medication, and the prescribing clinician was not notified.	(b)(5)	The HSA reiterated the requirements of CoreCivic Policy 13-70, *Pharmaceuticals* to nursing staff during the monthly medical meeting on December 20, 2017, which states that each time an inmate/detainee misses 3 consecutive doses or a pattern of missed doses is identified for the following types of medications: Anticonvulsants; Antipsychotics; Antidepressants, Isoniazid or other anti-tuberculosis medications; Anticoagulants; Lanoxin; HIV and HCV Medications; and any medications specifically prescribed by the licensed independent practitioner (LIP) for compliance monitoring,	1/5/18

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		that the inmate/detainee should be referred to a licensed nurse or LIP for discussion on non-compliance. Staff will sign a 4-2A Training Activity/Attendance Roster to acknowledge understanding of this requirement. Pending the meeting, the HSA will send a mass email to all shifts on the need to look at MARs more closely to identify any missed medications meeting the criteria for referral. Effective December 1, 2017, every Wednesday the Health Information Specialist (HIS) will generate a 3 consecutive missed medication report and submit it to the Pharmacy Nurse and Clinical Supervisor for review. The Pharmacy Nurse will create a log that will be maintained in the share drive to identify inmates/detainees who need medication education based on the requirements of CoreCivic Policy 13-70, Pharmaceuticals. Once the	

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		inmates are identified as needing education, the Pharmacy Nurse will call the inmate/detainee to medical to facilitate education and ensure the education is documented using the SOAPE format. Effective January 5, 2018, the HSA or Clinical Supervisor will review the log and the inmates/detainees chart to ensure that education is being completed as directed, which will be documented by signing the log. This review will continue until 95% compliance is achieved for 3 consecutive months.	
Quality of Care Finding: Continuity of Medication: In 3 of 10 (30%) cases during the intake screening, the period of time from order to first dose of medication exceeded 24 hours.	(b)(5)	The Clinical Supervisor (CS) will meet with the intake nurses to review the process for properly documenting KOP medications at intake, by December 20, 2017. In addition, the HSA will email all nursing staff to educate them on properly documenting in the MAR that the medications the inmate/detainee arrived	1/5/18

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		with were returned to the inmate/detainee as a KOP until it is time for the medication to be refilled. Follow-up training on these processes will occur during the monthly medical meeting on December 20, 2017, which will be documented on a 4-2A Training Activity/Attendance Roster. Effective January 1, 2018, the Pharmacy Nurse and QA Nurse will each review 5 charts that were received with medications (10 different charts total) from the night before to monitor compliance. Both the QA Nurse and the Pharmacy Nurse will maintain a log of the charts that were reviewed. Any incorrect MARs will be reported to the CS for immediate correction. Effective January 5, 2018, the Clinical Supervisor will conduct a review of 10 charts on a weekly basis, using the reviews logs created by the	

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		QA Nurse and Pharmacy Nurse, to verify the inmates/detainees medications are charted correctly when issued as a KOP at intake. The CS will maintain an overall/combined log of all charts reviewed. All discrepancies will be reported to the HSA. Continuous non-compliance may result in disciplinary action or re-assignment.	
Quality of Care Finding: HIV: One detainee was not seen by an HIV or ID specialist within 30 days of identification.	(b)(5)	The HSA will reiterate to nursing staff during the monthly medical meeting on December 20, 2017, that each time an inmate/detainee is identified at intake as being HIV positive, it must be documented on the inmates/detainees with medical conditions form and turned into the scheduler, Clinical Supervisor, and HSA so that the inmate/detainee can be scheduled to see an HIV Specialist. Staff will acknowledge understanding of this process by signing a 4-2A Training	1/1/18

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		Activity/Attendance Roster. Pending the meeting, the HSA will send a mass email to all shifts on the requirement to notify the Clinical Supervisor, Heath Services Administrator, and Medical Records and scheduler of any HIV positive detainees. Effective December 20, 2017, once the detainee is identified as being HIV positive, the Medical Records Clerk will send a request to PHS/ICE for authorization to see an outside HIV Specialist. Once the authorization has been received, the Medical Records Clerk will contact the local HIV Specialist to schedule an appointment. The appointment and reason for the appointment will be documented in the EMR, however the date will not be documented prior to the appointment for security reasons. Snap shot of the log is	

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		attached. Only 1 detainee since the audit has been HIV positive and needed to be scheduled but he left before his appointment date Effective January 1, 2018, the CID Nurse will review the inmates with medical conditions form daily to identify any HIV positive inmates/detainees. The CID Nurse will maintain a log of all HIV positive inmate/detainees in the facility. Once a week, the CID Nurse will cross reference the list with the authorizations for HIV appointments that the Medical Records Clerk maintains. All charts that are missing the ICE/PHS authorization or progress note by the Medical Records Clerk will be identified during the cross reference of the lists and the Clinical Supervisor or H.S.A will be notified immediately for correction. Continuous non-compliance for any stage of the process will be reported	

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DHS-ICE-20-0618-A-002882

		to the HSA for further action which may result in disciplinary action.	

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ICE Health Service Corps (IHSC)
Quality of Care Assessment

ICE Uniform Corrective Action Plan (April 2017 FMC Site Visit Follow-up)

Facility Name Central Arizona Florence Correctional Complex-East
Address (Street and Name) 1100 Bowling Road
City, State and Zip Code Florence, AZ 85132
County Pinal
Date[s] of FMC Follow-up 04/26/2017
Complete and Return to ICE HQ No Later Than:

Facility Corrective Action Plan Assigned to Phoenix ERO Field Office
Date of Final Submission: Nov. 9, 2017

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Report produced on May 12, 2017

AMERICAN OVERSIGHT

Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted medical findings to the fullest extent possible, and that it incorporates the recommendations. In the event a finding or recommendation cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

ICE Uniform Corrective Action Plan (FMC Reviews) Central Arizona Florence Correctional Complex-East (Phoenix AOR)			
Assessment and Findings	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
Detainee health appraisal not completed within a 14 day period. "Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition." (PBNDS 2008, 22/Medical Care/J./Health Appraisal)	(b)(5)	Effective May 16, 2017, the assigned CMA prints a daily list of inmate's out to court and the Provider Scheduler prints a daily list of scheduled health appraisals. The Provider Scheduler will compare the two lists and reschedule those inmates who are out to court to be seen within the next 24 hours. Following each clinic, the Provider Scheduler will verify	7/1/17

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		that all inmates scheduled for the clinic received their health appraisal according to the schedule. Inmates who missed their health appraisal will be scheduled to be seen within the next 24 hours. Effective July 1, 2017, the HSA or designee will review 20 charts monthly, for 3 months, to monitor compliance. Documentation of the charts reviewed and the status of compliance will be submitted to/maintained by the HSA.	
Quality of Care Finding: Time urgency was not included on orders for diagnostic services or specialty care.	(b)(5)	During the next weekly provider meeting, the HSA or designee will re-train the providers regarding the routine and stat timelines, as required by Policy 13-31. The training will be documented on a 4-2A Training Activity/Attendance Roster. Effective July 1, 2017, the HSA or designee will review 20 charts monthly, for 3 months, to monitor compliance. Documentation of the charts reviewed and the status of compliance will be submitted to/maintained by the HSA.	7/5/15

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ICE Health Service Corps (IHSC)
Health Care Compliance Assessment

ICE Uniform Corrective Action Plan (Follow Up to FMC Site Visit: May 2019)

Facility Name: Central Arizona Florence Correctional Complex-East	**Address (Full): 1155 N. Pinal Parkway**	
Date FMC Initiated Request for UCAP: 5/21/2019	**City: Florence**	**County: Pinal**
Complete and Return to IHSC FMC No Later Than: 7/10/2019	**State: AZ**	**Zip Code: 85132**
Name of Facility Staff Assigned to Develop / Oversee Corrective Action Plan: (b)(6); (b)(7)(C) **HSA**		
Date CAP Submitted by Facility: June 12, 2019		
IHSC Approver – Print Name (First, Last): (b)(6); (b)(7)(C)	**Title of IHSC Approver: Western Regional Field Medical Coordinator**	
Date CAP Approved by IHSC: February 21, 2020		
Signature and Date IHSC Closed Out CAP:	(b)(6); (b)(7)(C)	**February 25, 2020**

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Department of Homeland Security
Immigration and Customs Enforcement
Office of Enforcement and Removal Operations

Instructions for the Corrective Plan of Action Response

Provide a detailed description of the corrective action taken by the facility to address each of the findings identified in the ICE Health Service Corps Field Medical Coordinator (FMC) review. Please ensure that each stated corrective plan of action addresses the noted health care findings to the fullest extent possible, and that it incorporates the recommendations. In the event a corrective action cannot be implemented within the authorized timeline, please include an explanation in the "Corrective Plan of Action" column. The explanation should include a work around solution while pending final resolution, and an approximate completion date. If an extension is needed, the facility must contact the FMC with this request in advance of the specified timelines for submission.

****Exceptions to this timeline may be granted for necessary construction and staffing requirements, but will require an estimated completion date and temporary "work around" as part of the approved UCAP. Serious life and safety issues must be corrected immediately.***

ICE Uniform Corrective Action Plan (FMC Reviews) Central Arizona Florence Correctional Complex-East (Phoenix AOR)			
Assessment and Findings	**Corrective Plan of Action**	**Completion Date**	**Date of IHSC Verification of Implementation**
(b)(6); (b)(7)(C) Three of 20 (15%) detainees did not have a completed intake screening within 12 hours of booking into the facility. Per PBNDS 2008, "Initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function." (Medical Care) (V) (I) (1)	1). On 5/22/2019 H.S.A (b)(6); (b)(7)(C) to devise a plan on meeting the 12 hour requirement for ICE intakes. See 4-2A (Training roster). 2). On 5/22/2019 the discussed plan was typed on a memo and sent to staff. See attached memo from Assistant Chief (b)(6); (b)(7)(C) dated 5/22/2019.	6/14/2019	2/25/2020

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	3). On May 30th 2019 CS (b)(6); (b)(7)(C) conducted a monthly meeting with staff to go over the ICE intake plan and 12 hour requirement. See attached meeting minutes. 4). Effective June 17, 2019 the medical QA department will monitor up to 20 charts a month for the next three months to ensure the process is being effective. A log will be kept for three months with a goal of 90% compliance for the total of a three-month time frame. See attached email as a directive for monitoring.		

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LABORATORY TESTING

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Medical records, laboratory logs, sick call logs, chronic care logs

Sample: 10 orders for labs within the last 6 months (refer to User Guide for additional guidance)

Item #	Measure
1	Blood drawn or test done within 1 business day of ordered date?
2	Report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?
3	Clinical acknowledgment?
4	Appropriate clinical response?
5	Was patient advised of laboratory results?

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	NA	YES	YES	YES	YES
2		NA	YES	YES	YES	YES
3		NA	YES	YES	YES	YES
4		NA	YES	YES	YES	YES
5		NA	YES	YES	YES	YES
6		NA	YES	YES	YES	YES
7		NA	YES	YES	YES	YES
8		NA	YES	YES	YES	YES
9		NA	YES	YES	YES	YES
10		NA	YES	YES	YES	YES
	Total	0 / 0 NaN %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %

KEY: NA= not applicable

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DHS-ICE-20-0618-A-002890

MEDICAL RECORDKEEPING PRACTICES

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☑ Electronic ☐ Both Name of Electronic Health Record: Allscripts

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	Compliant	Compliant	Compliant	Compliant
Lab and diagnostic reports[6]	Compliant	Compliant	Compliant	Compliant	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	NA	NA	Compliant
Results of specialty consultations and referrals[7]	NA	NA	Compliant	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	NA	NA	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICAL RECORDKEEPING PRACTICES

DATE 04/27/2016 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Instructions: For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the narrative section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."

Sample: Ten records of detainees with chronic disease; two worksheets are required for this audit

Type of medical record: ☐ Paper ☑ Electronic ☐ Both Name of Electronic Health Record: Allscripts

	Alien #	Alien#	Alien #	Alien#	Alien #
	(b)(6); (b)(7)(C)				
Identifying information[2]	Compliant	Compliant	Compliant	Compliant	Compliant
Current Problem List[3]	Compliant	Compliant	Compliant	Compliant	Compliant
Receiving screen and health assessment forms	Compliant	Compliant	Compliant	Compliant	Compliant
Progress notes[4]	Compliant	Compliant	Compliant	Compliant	Compliant
Clinician orders for medication are signed	Compliant	Compliant	Compliant	Compliant	Compliant
MARs[5]	Compliant	NA	Compliant	NA	Compliant
Lab and diagnostic reports[6]	Compliant	NA	NA	NA	Compliant
Flowsheets	Compliant	Compliant	Compliant	Compliant	Compliant
Consents for medical care and treatment	Compliant	Compliant	Compliant	Compliant	Compliant
Signed refusals of care	NA	NA	Compliant	Compliant	Compliant
Results of specialty consultations and referrals[7]	NA	NA	NA	NA	NA
Discharge summaries from ED and hospitalizations	NA	NA	NA	NA	NA
Special needs treatment plan, where applicable	NA	NA	NA	NA	NA
Immunization records, where applicable	Compliant	Compliant	NA	NA	NA
Date and time of each encounter	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated medical, dental and mental health record	Compliant	Compliant	Compliant	Compliant	Compliant
Timely filing, within 72 hours	Compliant	Compliant	Compliant	Compliant	Compliant
Consolidated medical record[8]	Compliant	Compliant	Compliant	Compliant	Compliant
Content organized for easy retrieval of outside records, pertinent diagnostics and consultations	Compliant	Compliant	Compliant	Compliant	Compliant
EHR password protected	Compliant	Compliant	Compliant	Compliant	Compliant
Integrated health information with EHR, where applicable[9]	Compliant	Compliant	Compliant	Compliant	Compliant

[1] NCCHC 2014 J-H-01, J-H-03.[2] Detainee name, ID number, date of birth, gender.[3] Medical and mental health diagnoses and treatments; known allergies.[4] For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.[5] Placed in record within 2 weeks of previous month; [6]Acknowledged and dated. [7] Acknowledged and dated. [8] Records from prior stays incorporated. [9] Incorporation of information that arrives on paper into the EHR.

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION PRACTICES

DATE 04/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.

Source: MARS.

Sample: MAR and medical record for 10 patients. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.

1 Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up? YES
2 Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs? 5%
3 In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month? 0
4 Estimate the percentage of patients on self-administered medication ordered by a provider. 40%
5 OTCs provided by medical, commissary or both? Both

Item # Measure

1 What is the number of refusals and/or no shows during the previous month for each patient?
2 Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?
3 Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)

	A #	1	2	3
1	(b)(6); (b)(7)(C)	0	NA	NA
2		0	NA	NA
3		0	NA	NA
4		0	NA	NA
5		0	NA	NA
6		0	NA	NA
7		0	NA	NA
8		0	NA	NA
9		6	NA	NA
10		8	NA	NA
	Total		0 /0 NaN%	0 /0 NaN%

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002893

MENTAL HEALTH SCREEN

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for mental health evaluation.

Source: Intake screens of detainees, mental health referral logs, mental health caseload.

Sample: 10 randomly selected intake screens with positive mental health screens.

Item # Measure

1 Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days) ?

	A #	1
1	(b)(6); (b)(7)(C)	YES
2		YES
3		YES
4		YES
5		YES
6		YES
7		YES
8		YES
9		YES
10		YES
	Total	10 / 10 100 %

KEY: NA = Not Applicable

Revised February 2017

AMERICAN OVERSIGHT

MENTAL HEALTH TREATMENT PLANNING

DATE 04/27/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).

Source: Patients on mental health caseload, including all patients on psychotropic medication.

Sample: 10 patients selected from mental health caseload log or MARs, currently or recently in custody.

Item #	Measure
1	Is a clinical assessment, treatment, and follow-up plan documented?
2	Are treatment plans updated at a minimum of every 90 days?

	A #	1	2
1	(b)(6); (b)(7)(C)	YES	YES
2		YES	YES
3		YES	YES
4		YES	YES
5		YES	YES
6		YES	YES
7		YES	YES
8		YES	YES
9		NO	NA
10		NO	NA
	Total	8 / 8 100 %	8 / 8 100 %

KEY: NA = Not Applicable

NCCHC 2014 J-G-04 (Item 2)

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-002895

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information				
Facility Name:*	Central Arizona Florence Correctional Complex-East			
AOR:*	PHO			
Address:	1155 N. Pinal Parkway			
City:	Florence		**County:**	Pinal
State:*	AZ	**Zip:**	85132	
Inspection Information				
Start Date:*	5/7/2019			
End Date:*	5/9/2019			
Organization:*		IHSC		
# Detainees at Time of Visit:		364		
Total Facility Population at Time of Visit:		4520		
Facility Capacity:		4993		
Notes:				
Reviewer Information				
Lead Reviewer Name:*	(b)(6); (b)(7)(C)		**Date Signed:***	5/14/2019
Signature:	Invalid signature X (b)(6); (b)(7)(C) Signed by: (b)(6); (b)(7)(C)			

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Compliance Dashboard			
Subject Area	**Description**	**Compliance**	
ASM	Asthma	75%	
CG	Complaints and Grievance	21	*Total Number
CM	Continuity of Medications	95%	
DC	Dental Care	100%	
DM	Diabetes	99%	
DSA	Diagnostic Services and Specialty Care Access	100%	
EED	Evaluation of Care Prior to Emergency Department	100%	
HA	Health Assessment	97%	
HIV	Human Immunodeficiency Virus	80%	
HTN	Hypertension	100%	
LT	Laboratory Testing	100%	
MR	Medical Recordkeeping	100%	
MAR	Medication Administration Records	100%	
MHS	Mental Health Screen	100%	
MHT	Mental Health Treatment Planning	100%	
PG	Pregnant Women		
SZ	Seizure Disorder	100%	
SS	Suicide Screening	100%	
TD	Treatment of Disability	100%	
UC	Urgent Care (Sick Call)	100%	

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IGSA STAFFING MATRIX	
	**1 FTE = 40 hours / per week*
Position	(b)(7)(E)
C.N.A.	
Dental Assistant	
Dentist	
EMT	
H.S.A.	
LVN/LPN	
MH Counselor	
MRT	
NP/PA	
Nurse Manager	
Paramedic	
Pharmacist	
Pharmacy Tech	
Physician	
Psychiatrist	
Psychologist	
RN	
Social Worker	
X-ray Tech	
Other 1	
Other 2	
TOTAL	

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INTRODUCTION TO THE QMC

These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc.

Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.

- These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
- The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
- The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.

- The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody $\geq$ 14 days.
- In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
- While the goal is 100% compliance, the performance objective for most of the audit tools is $\geq$ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
- The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
- In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.

AUDIT TOOL COMPLETION

Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer.

Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.

TIPS FOR REVIEWERS

- Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

- Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.

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• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

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Term	Description
A#	Enter A# in format 123456789. Omit all leading characters such as "A".
N/A - LOS	N/A Due to Length of Stay
N/A - NLOS	N/A Not Due to Length of Stay
ASM	Asthma
CG	Complaints and Grievance
CM	Continuity of Medications
DC	Dental Care
DM	Diabetes
DSA	Diagnostic Services and Specialty Care Access
EED	Evaluation of Care Prior to Emergency Department
HA	Health Assessment
HIV	Human Immunodeficiency Virus
HTN	Hypertension
LT	Laboratory Testing
MR	Medical Recordkeeping
MAR	Medication Administration Records
MHS	Mental Health Screen
MHT	Mental Health Treatment Planning
PG	Pregnant Women
SZ	Seizure Disorder
SS	Suicide Screening
TD	Treatment of Disability
UC	Urgent Care (Sick Call)

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ASTHMA (MODERATE AND SEVERE)						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		5				
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs (Medical Administrative Record).					
Sample:	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf Peak Expiratory Flow Rates, (Sept, 2016) http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm					
Remarks:	POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" PREVIOUS FINDINGS (May 2018): One of six (17%) did not have a peak flow measurement completed during the physical exam.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019	
Facility (f)						
fASM-1a:	Does the facility follow a particular clinical practice guideline to manage asthma?				Y	
fASM-1b:	If yes, what is the guideline?		NCCHC			
Clinical (c)						
cASM-1	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cASM-2	Was a peak flow completed at the initial physical exam?					
cASM-3	Was a peak flow completed at the CC visit or within the last 3 months?					
cASM-4	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.					
Total Applicable:		5	5	5	5	
Total Met:		5	0	5	5	
% Compliance:	75%	100%	0%	100%	100%	
Patient(s)	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**	
1	(b)(6); (b)(7)(C)	Yes	No	Yes	Yes	
2		Yes	No	Yes	Yes	
3		Yes	No	Yes	Yes	
4		Yes	No	Yes	Yes	
5		Yes	No	Yes	Yes	
6		Select	Select	Select	Select	
7		Select	Select	Select	Select	
8		Select	Select	Select	Select	
9		Select	Select	Select	Select	
10		Select	Select	Select	Select	

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DIABETES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10	
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.	
Source:	Chronic disease registry or MARs.	
Sample:	10 patients with diabetes chosen at random, if available.	
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines	
Remarks:	(b)(6); (b)(7)(C) refused his labs. Refusal form signed. (b)(6); (b)(7)(C) did not report on intake that he was diabetic and did not report taking medications for diabetes. POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" PREVIOUS FINDINGS (May 2018): Two of nine (22%) did not have a blood sugar measured at intake.	
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:** 5/7/2019

	Facility (f)	
fDM-1:	What clinical practice guideline does the facility use to manage diabetes?	NCCHC

	Clinical (c)
cDM-1	Was blood sugar measured and recorded on intake?
cDM-2	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.)
cDM-3	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?
cDM-4	Were lipids measured within one year?
cDM-5	Was patient followed at least every 90 days with appropriate vital signs?
cDM-6	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.
cDM-7	Was degree of control (goal HgbA1C <8.0) documented?
cDM-8	Was a strategy to attain diabetes control documented if HgbA1C was above goal?

Total Applicable:		9	10	9	9	10	1	9	3
Total Met:		8	10	9	9	10	1	9	3
% Compliance:	99%	89%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**	**cDM-8**
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A - NLOS
3		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes
4		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS
5		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	Yes

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Patient(s)	A# (numbers only)	cDM-1	cDM-2	cDM-3	cDM-4	cDM-5	cDM-6	cDM-7	cDM-8	
6	(b)(6); (b)(7)(C)	No	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	
7		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	
8		Yes	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	
9		Yes	Yes	N/A - NLOS	N/A - NLOS	Yes	N/A - NLOS	N/A - NLOS	N/A - NLOS	
10		N/A	Yes	Yes	Yes	Yes	N/A - NLOS	Yes	N/A - NLOS	

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HIV							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3						
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.						
Source:	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.						
Sample:	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.						
Guidelines:	National Institutes of Health. Aids Info.	https://aidsinfo.nih.gov/guidelines	http://nccc.ucsf.edu				
	University of California, San Francisco. HIV Clinical Consultation Center.						
	ACA Standard Reference: ACA 2004 4-ALDF-4C-18						
Remarks:	(b)(6); (b)(7)(C) is scheduled for his Infectious Disease consult on 6/25/2019. This is the earliest appointment that was available. (b)(6); (b)(7)(C) left the facility after 20 days. POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" PREVIOUS FINDINGS (May 2018): One detainee was not seen by an HIV or ID specialist within 30 days of identification. One detainee had a CD4 and viral load ordered, but it was not completed within 14 days of arrival to the facility.						
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/7/2019			
Facility (f)							
fHIV-1:	What clinical practice guideline does the facility use to manage HIV?	NCCHC					
Clinical (c)							
cHIV-1	How was HIV status identified? By laboratory, prior medical records or patient report?						
cHIV-2	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?						
cHIV-3	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?						
cHIV-4	Was antiretroviral treatment considered and documented?						
cHIV-5	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?						
cHIV-6	Was a chest x-ray completed within 72 hours of problem identification, if not already done?						

Total Applicable:			2	2	3	2	3
Total Met:			2	0	3	2	3
% Compliance:	80%		100%	0%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**

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Patient(s)	A# (numbers only)	cHIV-1	cHIV-2	cHIV-3	cHIV-4	cHIV-5	cHIV-6	
1	(b)(6); (b)(7)(C)	Medical Record	Yes	No	Yes	Yes	Yes	
2		Medical Record	N/A - LOS	N/A - LOS	Yes	N/A - LOS	Yes	
3		Medical Record	Yes	No	Yes	Yes	Yes	
4		Select	Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	Select	

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HYPERTENSION						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with hypertension chosen at random, if available.					
Guidelines:	NCCHC Federal Clinical Guidelines https://www.ncchc.org/federal-clinical-guidelines					
Remarks:	POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" PREVIOUS FINDINGS (May 2018): One of nine (11%) did not have a documented blood pressure on the medical intake.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019	
Facility (f)						
fHTN-1a:	Does the facility follow a clinical practice guideline to manage hypertension?				Y	
fHTN-1b:	If yes, what is the guideline?		NCCHC			
Clinical (c)						
cHTN-1	Was a blood pressure reading noted at intake?					
cHTN-2	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-3	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cHTN-4	Was a chronic disease guideline, including baseline laboratory testing, followed?					
Total Applicable:		10	10	1	10	
Total Met:		10	10	1	10	
% Compliance:	100%	100%	100%	100%	100%	

Patient(s)	A# (numbers only)	cHTN-1	cHTN-2	cHTN-3	cHTN-4
1	(b)(6); (b)(7)(C)	Y	Yes	N/A - NLOS	Yes
2		Y	Yes	Yes	Yes
3		Y	Yes	N/A - NLOS	Yes
4		Y	Yes	N/A - NLOS	Yes
5		Y	Yes	N/A - NLOS	Yes
6		Y	Yes	N/A - NLOS	Yes
7		Y	Yes	N/A - NLOS	Yes
8		Y	Yes	N/A - NLOS	Yes
9		Y	Yes	N/A - NLOS	Yes
10		Y	Yes	N/A - NLOS	Yes

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SEIZURE DISORDER						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	3					
Purpose:	To prevent deterioration in function and cost of unnecessary care.					
Source:	Chronic disease registry or MARs.					
Sample:	10 patients with seizure disorder chosen at random, if available.					
Guidelines:						
Remarks:	(b)(6); (b)(7)(C) refused his 14 day PE. Refusal form completed. POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" PREVIOUS FINDINGS (May 2018): No findings noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019	
Facility (f)						
fSZ-1:	What clinical practice guideline does the facility use to manage seizures?	NCCHC				
Clinical (c)						
cSZ-1	Was an appropriate neurological history completed at the initial physical examination?					
cSZ-2	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.					
cSZ-3	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?					
cSZ-4	Was a treatment plan established?					
cSZ-5	Are there orders for a bottom bunk?					
Total Applicable:		2	3	3	3	3
Total Met:		2	3	3	3	3
% Compliance:	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**
1	(b)(6); (b)(7)(C)	N/A - NLOS	Yes	Yes	Yes	Yes
2		Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes
4		Select	Select	Select	Select	Select
5		Select	Select	Select	Select	Select
6		Select	Select	Select	Select	Select
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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CONTINUITY OF MEDICATIONS			
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10		
Purpose:	To assess timeliness of medication, as ordered.		
Source:	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).		
Sample:	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.		
Guidelines:			
Remarks:	(b)(6); (b)(7)(C) was noted to have a history of HIV on intake. The HIV meds were not in stock at the facility and had to be ordered. He received his first dose 2 days after ordered. POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008. When a detainee arrives to the facility with chronic medications, the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated, until the physical exam, at which time it is reordered as necessary. PREVIOUS FINDINGS (May 2018): In 2 of 10 (20%) cases, the period of time from order to first dose exceeded 24 hours.		
Reviewer:	(b)(6); (b)(7)(C)	**Date Reviewed:**	5/8/2019

Clinical (c)			
cCM-1	Period of time from completion of intake screening to the ordering of medications less than 24 hours?		
cCM-2	Period of time from order to first dose less than 24 hours?		
Total Applicable:		10	10
Total Met:		10	9
% Compliance:	95%	100%	90%

Patient(s)	A# (numbers only)	cCM-1	cCM-2
1	(b)(6); (b)(7)(C)	Yes	No
2		Yes	Yes
3		Yes	Yes
4		Yes	Yes
5		Yes	Yes
6		Yes	Yes
7		Yes	Yes
8		Yes	Yes
9		Yes	Yes
10		Yes	Yes

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DENTAL CARE						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10				
Purpose:	To assess compliance with detention standards and continuity of care.					
Source:	Dental sick call list or dental referral log.					
Sample:	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.					
Guidelines:	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.					
Remarks:	POLICIES REVIEWED: Policy 13-13 "Dental Care" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019	
Clinical (c)						
cDC-1	Was patient screened for symptoms during the intake process?					
cDC-2	Was patient evaluated by a qualified health professional within 48 hours of request?					
cDC-3	Do dental clinical notes describe findings, diagnosis, treatment, and plans?					
cDC-4	Was the patient scheduled for follow-up treatment as recommended?					
Total Applicable:		10	10	10	9	
Total Met:		10	10	10	9	
% Compliance:	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**	
1	(b)(6); (b)(7)(C)	Y	Yes	Yes	Yes	
2		Y	Yes	Yes	N/A - NLOS	
3		Y	Yes	Yes	Yes	
4		Y	Yes	Yes	Yes	
5		Y	Yes	Yes	Yes	
6		Y	Yes	Yes	Yes	
7		Y	Yes	Yes	Yes	
8		Y	Yes	Yes	Yes	
9		Y	Yes	Yes	Yes	
10		Y	Yes	Yes	Yes	

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DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10					
Purpose:	To assess timeliness of off-site diagnostic services and specialty care.					
Source:	Referrals log, medical records or MedPars.					
Sample:	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.					
Guidelines:	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.					
Remarks:	POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" and Policy 13-64 "Off Site Care and Consultations" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019	

Clinical (c)						
cDSA-1	Was there a documented time urgency included on the order for specialty care or diagnostic services?					
cDSA-2	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., "return in 90 days"?					
cDSA-3	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?					
cDSA-4	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?					
Total Applicable:			10	10	10	10
Total Met:			10	10	10	10
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**
1	(b)(6); (b)(7)(C)	Orthopedics	Yes	Yes	Yes	Yes
2		Other	Yes	Yes	Yes	Yes
3		Other	Yes	Yes	Yes	Yes
4		General Surgery	Yes	Yes	Yes	Yes
5		Orthopedics	Yes	Yes	Yes	Yes
6		Orthopedics	Yes	Yes	Yes	Yes
7		Orthopedics	Yes	Yes	Yes	Yes
8		Opthalmology	Yes	Yes	Yes	Yes
9		Other	Yes	Yes	Yes	Yes
10		Orthopedics	Yes	Yes	Yes	Yes

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EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10							
Purpose:	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbound patients.							
Source:	Emergency Department (ED) logs.							
Sample:	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain.							
Guidelines:	NCCHC 2014 J-E-12.							
Remarks:	POLICIES REVIEWED: Policy 13-34 "Medical Emergency Response" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.							
Reviewer:	(b)(6); (b)(7)(C)					**Date Reviewed:**	5/7/2019	
Clinical (c)								
cEED-1	Is there an outbound progress note?							
cEED-2	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks portion of the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the report comments.							
cEED-3	Is there discharge documentation from the hospital or ED in the chart?							
cEED-4	Is there an inbound assessment?							
cEED-5	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?							
Total Applicable:			10	10	10	10	10	
Total Met:			10	10	10	10	10	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**	
1	(b)(6); (b)(7)(C)	Self-inflicted laceration	Yes	No	Yes	Yes	Yes	
2		Swallowed batteries	Yes	No	Yes	Yes	Yes	
3		SOB	Yes	No	Yes	Yes	Yes	
4		Swollen eyes	Yes	No	Yes	Yes	Yes	
5		Chest Pain	Yes	No	Yes	Yes	Yes	
6		Abdominal Pain	Yes	No	Yes	Yes	Yes	
7		Foreign Object	Yes	No	Yes	Yes	Yes	
8		Knee infection	Yes	No	Yes	Yes	Yes	
9		Hunger strike evaluation	Yes	No	Yes	Yes	Yes	
10		Thrombocytopenia	Yes	No	Yes	Yes	Yes	

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COMPLAINTS AND GRIEVANCES							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	21						
Purpose:	To assess use of medical grievance data as part of the quality management program.						
Source:	Facility grievance logs.						
Sample:	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
Guidelines:	NCCHC 2014 J-A-06, J-A-11.						
Remarks:	Most complaints in the other category are for medication or mental health requests. POLICIES REVIEWED: Policy 13-08 "Complaint Resolution" and Policy 14-05 "Inmate-Resident Grievance Procedures." According to the Health Service Administrator, all dorms have access to grievance forms and a locked drop box labeled for this purpose. The sick call nurse picks them up daily. All medical grievances are then given to the Clinical Supervisor, an RN, and reviewed. The CS is responsible for answering all medical grievances within 5 business days. After they are addressed, they are scanned into the health record. A grievance log is maintained to evaluate for trends in grievances PREVIOUS FINDINGS (May 2018): No findings noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/7/2019		
Facility (f)							
fCG-1:	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care? If yes, please address in the remarks section whether and how the facility uses this information to implement change.				N		
fCG-2:	How many medical grievances were submitted over the past 3 months?			36			
fCG-3:	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?			36			
Clinical (c)							
cCG-1	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
cCG-2	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
Totals:	21	0	0	2	6	3	25
Patient(s)	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
1	(b)(6); (b)(7)(C)	Select	Select	Select	Select	Select	3
2		Select	Select	Select	4	1	Select
3		Select	Select	Select	Select	Select	1
4		Select	Select	1	Select	Select	2
5		Select	Select	Select	Select	Select	1
6		Select	Select	Select	1	Select	4
7		Select	Select	Select	Select	Select	1
8		Select	Select	Select	Select	Select	1
9		Select	Select	Select	Select	Select	1
10		Select	Select	Select	Select	Select	1
11		Select	Select	Select	Select	Select	3
12		Select	Select	Select	Select	1	1
13		Select	Select	Select	1	Select	Select
14		Select	Select	Select	Select	Select	1
15		Select	Select	Select	Select	Select	1
16		Select	Select	Select	Select	Select	1
17		Select	Select	Select	Select	Select	1
18		Select	Select	Select	Select	Select	1
19		Select	Select	1	Select	Select	Select
20		Select	Select	Select	Select	Select	1
21		Select	Select	Select	Select	1	Select
22		Select	Select	Select	Select	Select	Select
23		Select	Select	Select	Select	Select	Select
24		Select	Select	Select	Select	Select	Select
25		Select	Select	Select	Select	Select	Select
26		Select	Select	Select	Select	Select	Select
27		Select	Select	Select	Select	Select	Select
28		Select	Select	Select	Select	Select	Select
29		Select	Select	Select	Select	Select	Select
30		Select	Select	Select	Select	Select	Select

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Patient(s)	A# (numbers only)	Availability of care (sick call hours, etc.)	Denial or refusal of specific request(s) for care	Delay(s) in care	Competency/professional skillset of medical staff	Attitude, demeanor or conduct of staff	Other
31		Select	Select	Select	Select	Select	Select
32		Select	Select	Select	Select	Select	Select
33		Select	Select	Select	Select	Select	Select
34		Select	Select	Select	Select	Select	Select
35		Select	Select	Select	Select	Select	Select
36		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

HEALTH ASSESSMENT						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	20					
Purpose:	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.					
Source:	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.					
Sample:	20 medical records chosen at random.					
Guidelines:	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25					
Remarks:	According to the Health Service Administrator, medical is not getting access to the ICE detainees in a timely manner from security for the intake screenings. POLICIES REVIEWED: Policy 13-40 "Health Appraisals" is compliant with ICE PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019	
Clinical (c)						
cHA-1	Initial screen complete within 12 hours of booking?					
cHA-2	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?					
cHA-3	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?					
cHA-4	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.					
cHA-5	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.					
Total Applicable:		20	20	2	18	20
Total Met:		17	20	2	18	20
% Compliance:	97%	85%	100%	100%	100%	100%

Patient(s)	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**
1	(b)(6); (b)(7)(C)	Yes	Yes	N/A	Yes	Yes
2		Yes	Yes	N/A	Yes	Yes
3		No	Yes	N/A	Yes	Yes
4		Yes	Yes	N/A	Yes	Yes
5		Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	N/A	Yes	Yes
7		Yes	Yes	N/A	Yes	Yes
8		No	Yes	N/A	Yes	Yes
9		Yes	Yes	N/A	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes
11		No	Yes	N/A	Yes	Yes
12		Yes	Yes	N/A	Yes	Yes
13		Yes	Yes	N/A	Yes	Yes
14		Yes	Yes	N/A	Yes	Yes
15		Yes	Yes	N/A	Yes	Yes
16		Yes	Yes	N/A	N/A - NLOS	Yes
17		Yes	Yes	N/A	Yes	Yes
18		Yes	Yes	N/A	Yes	Yes
19		Yes	Yes	N/A	Yes	Yes
20		Yes	Yes	N/A	N/A - NLOS	Yes

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LABORATORY TESTING							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10					
Purpose:	To assess timeliness, continuity, and coordination of care.						
Source:	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
Sample:	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
Guidelines:							
Remarks:	None of the charts reviewed contained STAT or acute lab work orders. These are all routine labs. POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019		
Clinical (c)							
cLT-1	Was blood drawn or test done within 1 business day of ordered date?						
cLT-2	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
cLT-3	Was there clinical acknowledgment?						
cLT-4	Was there an appropriate clinical response?						
cLT-5	Was patient advised of laboratory results?						
Total Applicable:		10	10	10	10	8	
Total Met:		10	10	10	10	8	
% Compliance:	100%	100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	Yes	Yes	
2		Yes	Yes	Yes	Yes	N/A - LOS	
3		Yes	Yes	Yes	Yes	Yes	
4		Yes	Yes	Yes	Yes	Yes	
5		Yes	Yes	Yes	Yes	Yes	
6		Yes	Yes	Yes	Yes	Yes	
7		Yes	Yes	Yes	Yes	Yes	
8		Yes	Yes	Yes	Yes	Yes	
9		Yes	Yes	Yes	Yes	N/A - LOS	
10		Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

MEDICATION ADMINISTRATION RECORDS									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.								
Source:	MARS.								
Sample:	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.								
Guidelines:									
Remarks:	POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008. -CAFCC-East currently uses electronic medication administration records. During direct observation, there was no evidence that staff was pre-pouring medication. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly. PREVIOUS FINDINGS (May 2018): No findings noted.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/9/2019				
Facility (f)									
fMAR-1:	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?				Y				
fMAR-2:	Based on review of current month MARs or previous month's MARs, if available, what percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?				10				
fMAR-3:	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?				0				
fMAR-4:	Estimate the percentage of patients on self-administered medication ordered by a provider.				35				
fMAR-5:	OTCs provided by medical, commissary or both?				Both				
Clinical (c)									
cMAR-1	What is the number of refusals and no shows during the previous month for each patient?								
cMAR-2	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?								
cMAR-3	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)								
Total Applicable:			2	2					
Total Met:			2	2					
% Compliance:	100%		100%	100%					
Patient(s)	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**					
1	(b)(6); (b)(7)(C)	3	N/A - NLOS	N/A - NLOS					
2		2	N/A - NLOS	N/A - NLOS					
3		4	N/A - NLOS	N/A - NLOS					
4		2	N/A - NLOS	N/A - NLOS					
5		2	N/A - NLOS	N/A - NLOS					
6		1	N/A - NLOS	N/A - NLOS					
7		4	Yes	Yes					
8		13	Yes	Yes					
9		3	N/A - NLOS	N/A - NLOS					
10		4	N/A - NLOS	N/A - NLOS					

AMERICAN OVERSIGHT

MEDICAL RECORD-KEEPING PRACTICES

Number of Files Reviewed for Patients Meeting this Criteria:* (please select # of no files/patients reviewed)	10
Purpose:	To assess completeness of the medical record and appropriateness of medical record practices.
Source:	Medical Records, Chronic Care Log, and MARs.
Sample:	10 records of detainees with chronic disease, if available.
Instructions:	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For example, if most of the progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."
Guidelines:	NCCHC 2014 J-H-01, J-H-03.
Remarks:	POLICIES REVIEWED: Policy 13-58 "Medical Records" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.
Reviewer:	(b)(6); (b)(7)(C) **Date Reviewed:** 5/8/2019

	Facility (f)	
fMR-1:	Type of Medical Records?	Electronic
fMR-2:	Name of Electronic Health Record?	Allscripts

Total Applicable:		10	10	10	10	10	10	10	10	10	9	6	1	8	9	10	10	10	10	10	10	10	10
Total Met:		10	10	10	10	10	10	10	10	10	9	6	1	8	9	10	10	10	10	10	10	10	10
% Compliance:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments, known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**	**MARs:** Placed in record within 2 weeks of previous month	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
1	(b)(6); (b)(7)(C)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
8		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
9		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
10		Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

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MENTAL HEALTH SCREEN									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	10								
Purpose:	To assess conformance with nationally-accepted guidelines for mental health evaluation.								
Source:	Intake screens of detainees, mental health referral logs, mental health caseload.								
Sample:	10 randomly selected intake screens with positive mental health screens, if available.								
Guidelines:									
Remarks:	POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008. All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility. PREVIOUS FINDINGS (May 2018): No findings noted.								
Reviewer:	(b)(6); (b)(7)(C)		**Date Reviewed:**	5/8/2019					
Clinical (c)									
cMHS-1	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.								
Total Applicable:		10							
Total Met:		10							
% Compliance:	100%	100%							
Patient(s)	**A# (numbers only)**	**cMHS-1**							
1	(b)(6); (b)(7)(C)	Yes							
2		Yes							
3		Yes							
4		Yes							
5		Yes							
6		Yes							
7		Yes							
8		Yes							
9		Yes							
10		Yes							

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MENTAL HEALTH TREATMENT PLANNING									
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10							
Purpose:	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).								
Source:	Patients on mental health caseload, including all patients on psychotropic medication.								
Sample:	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.								
Guidelines:	NCCHC 2014 J-G-04 (Item 2)								
Remarks:	POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008. Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake screening. Detainees who screen positive are referred to a mental health provider and are generally seen on the next day. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility. PREVIOUS FINDINGS (May 2018): No findings noted.								
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019				
Clinical (c)									
cMHT-1	Is a clinical assessment, treatment, and follow-up plan documented?								
cMHT-2	Are treatment plans updated at a minimum of every 90 days?								
Total Applicable:		10	10						
Total Met:		10	10						
% Compliance:	100%	100%	100%						
Patient(s)	**A# (numbers only)**	**cMHT-1**	**cMHT-2**						
1	(b)(6); (b)(7)(C)	Yes	Yes						
2		Yes	Yes						
3		Yes	Yes						
4		Yes	Yes						
5		Yes	Yes						
6		Yes	Yes						
7		Yes	Yes						
8		Yes	Yes						
9		Yes	Yes						
10		Yes	Yes						

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PREGNANT WOMEN							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		0					
Purpose:	To determine compliance with detention standards and continuity and coordination of care.						
Source:	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
Sample:	10 pregnant detainees, if available.						
Guidelines:	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
Remarks:	N/A. Females are not housed at the facility.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019		
Facility (f)							
fPG-1:	Does the facility perform a pregnancy test on females aged 10 to 56 during intake screening?			Select			
Clinical (c)							
cPG-1	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
cPG-2	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
cPG-3	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
cPG-4	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
cPG-5	Were prenatal vitamins prescribed?						
Total Applicable:		0	0	0	0	0	
Total Met:		0	0	0	0	0	
% Compliance:							
Patient(s)	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
1		Select	Select	Select	Select	Select	
2		Select	Select	Select	Select	Select	
3		Select	Select	Select	Select	Select	
4		Select	Select	Select	Select	Select	
5		Select	Select	Select	Select	Select	
6		Select	Select	Select	Select	Select	
7		Select	Select	Select	Select	Select	
8		Select	Select	Select	Select	Select	
9		Select	Select	Select	Select	Select	
10		Select	Select	Select	Select	Select	

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SUICIDE SCREENING						
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)	6					
Purpose:	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.					
Source:	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Sample:	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.					
Guidelines:	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32					
Remarks:	POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008. -CAFCC-East performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts. -CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility. PREVIOUS FINDINGS (May 2018): No findings noted.					
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019	
Facility (f)						
fSS-1:	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?			6		
fSS-2:	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?			Y		
fSS-3:	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?			Y		
Clinical (c)						
cSS-1	What type of monitoring was practiced while the patient was on suicide watch?					
cSS-2	Were checks documented consistently?					
cSS-3	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?					
cSS-4	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?					
cSS-5	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.					
Total Applicable:			6	6	6	6
Total Met:			6	6	6	6
% Compliance:	100%		100%	100%	100%	100%
Patient(s)	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**
1	(b)(6); (b)(7)(C)	Constant (1:1)	Yes	Yes	Yes	No
2		Constant (1:1)	Yes	Yes	Yes	No
3		Constant (1:1)	Yes	Yes	Yes	No
4		Constant (1:1)	Yes	Yes	Yes	No
5		Constant (1:1)	Yes	Yes	Yes	No
6		At least q 15 min	Yes	Yes	Yes	No
7		Select	Select	Select	Select	Select
8		Select	Select	Select	Select	Select
9		Select	Select	Select	Select	Select
10		Select	Select	Select	Select	Select

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TREATMENT OF DISABILITY							
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		3					
Purpose:	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.						
Source:	hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
Sample:	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
Guidelines:	NCCHC J-G-02.						
Remarks:	POLICIES REVIEWED: Policy 13-82 "Special needs Treatment Plans" is compliant with PBNDS 2008. PREVIOUS FINDINGS (May 2018): No findings noted.						
Reviewer:	(b)(6); (b)(7)(C)			**Date Reviewed:**	5/8/2019		
Facility (f)							
fTD-1:	Does the facility maintain a current list of all patients with disabilities on site?				Y		
Clinical (c)							
cTD-1	Is the disability prominently noted in the file, along with any needed accommodations?						
cTD-2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
cTD-3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
cTD-4	Was ADL assistance provided, if applicable?						
Total Applicable:		3	3	3	1		
Total Met:		3	3	3	1		
% Compliance:	100%	100%	100%	100%	100%		
Patient(s)	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
1	(b)(6); (b)(7)(C)	Yes	Yes	Yes	N/A - NLOS		
2		Yes	Yes	Yes	Yes		
3		Yes	Yes	Yes	N/A - NLOS		
4		Select	Select	Select	Select		
5		Select	Select	Select	Select		
6		Select	Select	Select	Select		
7		Select	Select	Select	Select		
8		Select	Select	Select	Select		
9		Select	Select	Select	Select		
10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)								
Number of Files Reviewed for Patients Meeting this Criteria:* (please select 0 if no files/patients reviewed)		10						
Purpose:	To assess for timely and appropriate nursing care for acute conditions.							
Source:	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.							
Sample:	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.							
Guidelines:	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.							
Remarks:	POLICIES REVIEWED: Policy 13-80 "Sick Call" is compliant with PBNDS 2008. According to the HSA, the sick call process is initiated by a detainee filling out a paper sick call request. Sick call is done seven days a week. A nurse picks up sick call requests daily and they are addressed within 24 hours. PREVIOUS FINDINGS (May 2018): No findings noted.							
Reviewer:		(b)(6); (b)(7)(C)				**Date Reviewed:**	5/9/2019	
Clinical (c)								
cUC-1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?							
cUC-2	Was care delivered within the scope of the nurse's license?							
cUC-3	Were vital signs documented during the nurse's assessment?							
cUC-4	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?							
cUC-5	If referred, was an MD/PA/NP/DMD assessment and plan documented?							
Total Applicable:			10	10	10	4	4	
Total Met:			10	10	10	4	4	
% Compliance:	100%		100%	100%	100%	100%	100%	
Patient(s)	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**	
1	(b)(6); (b)(7)(C)	Toothache	Yes	Yes	Yes	Yes	Yes	
2		Toothache	Yes	Yes	Yes	Yes	Yes	
3		Fever and sore throat	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
4		Earache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
5		Headache	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
6		Dizziness	Yes	Yes	Yes	Yes	Yes	
7		Leg and lower back pain	Yes	Yes	Yes	Yes	Yes	
8		Burn to right leg with hot water	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
9		Acne	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	
10		Cold and cough	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS	

AMERICAN OVERSIGHT

SUICIDE SCREENING

DATE 04/28/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.

Source: Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

Sample: Medical records for 10 patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.

1 What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review? 12

2 Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation? ■ Yes ☐ No

3 Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)? ■ Yes ☐ No

Item # Measure

1 Was the suicidal patient evaluated by a mental health professional within 24 hours of identification (unless the situation was emergent in which case the evaluation should be immediate)?

2 Was the patient evaluated by a qualified mental health professional daily while on suicide watch?

3 What type of monitoring was practiced while the patient was on suicide watch?

4 Were checks documented consistently?

5 Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe.

	A #	1	2	3	4	5
1	(b)(6); (b)(7)(C)	YES	YES	Constant (1:1)	YES	NO
2		YES	YES	At Least q15 min	YES	NO
3		YES	YES	Constant (1:1)	YES	NO
4		YES	YES	At least q15min	YES	NO
5		YES	YES	Constant (1:1)	YES	NO
6		YES	YES	Constant (1:1)	YES	NO
7		YES	YES	Constant (1:1)	YES	NO
8		YES	YES	At least q15min	YES	NO
9		YES	YES	Constant (1:1)	YES	NO
10		YES	YES	At least q15min	YES	NO
	Total	10 / 10 100 %	10 / 10 100 %		10 / 10 100 %	0 / 0 NaN %

KEY: NA= not applicable

NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32

AMERICAN OVERSIGHT

TREATMENT OF DISABILITY

DATE: 04/26/2017 REVIEWER: (b)(6); (b)(7)(C)

FACILITY REVIEWED: Central Arizona Florence Correctional Complex-East

Purpose: To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment.
See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf

Sources: Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.

Sample: 10 patients within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

General Question: Does the facility maintain a current list of all patients with disabilities on site? YES

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations?
2	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?
3	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?
4	Was ADL assistance provided, if applicable?

	A #	1	2	3	4
1	(b)(6); (b)(7)(C)	YES	YES	YES	YES
2		YES	YES	NA	NA
3		YES	YES	NA	NA
4		YES	YES	NA	NA
5		YES	YES	NA	NA
6		YES	YES	NA	NA
7		YES	YES	NA	NA
8		YES	YES	NA	NA
9		YES	YES	NA	NA
10		YES	YES	NA	NA
	TOTALS	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %	1 / 1 100 %

KEY: NA = not applicable

AMERICAN OVERSIGHT

URGENT CARE (SICK CALL)

DATE 04/26/2017 REVIEWER (b)(6); (b)(7)(C)

FACILITY REVIEWED Central Arizona Florence Correctional Complex-East

Purpose: To assess for timely and appropriate nursing care for acute conditions.

Source: Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.

Sample: 10 urgent care visits by detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review. Common potentially serious complaints include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.

Item #	Measure
1	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?
2	Was care delivered within the scope of the nurse's license?
3	Were vital signs documented during the nurse's assessment?
4	If necessary, was a nursing referral to a MD/PA/NP/DMD submitted within 24 hour where appropriate?
5	If referred, was an MD/PA/NP/DMD assessment and plan documented?

	A #	Chief Complaint	1	2	3	4	5
1	(b)(6); (b)(7)(C)	Headache	YES	YES	YES	NA	NA
2		Watery eyes	YES	YES	YES	NA	NA
3		Cold	YES	YES	YES	NA	NA
4		Dizziness	YES	YES	YES	YES	YES
5		Sore Throat	YES	YES	YES	NA	NA
6		URI, Wheezing	YES	YES	YES	YES	YES
7		Congestion, Headache	YES	YES	YES	NA	NA
8		Blurry vision	YES	YES	YES	YES	YES
9		Knee pain	YES	YES	YES	NA	NA
10		Headache	YES	YES	YES	NA	NA
		Total	10 / 10 100 %	10 / 10 100 %	10 / 10 100 %	3 / 3 100 %	3 / 3 100 %

KEY: NA= not applicable

NCCHC 2014 J-A-01, J-E-07; ACA 2014 4-ALDF-4C-03, 4-ALDF-4D-03

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DEPARTMENT OF HOMELAND SECURITY
ICE Health Service Corps

FINAL REPORT OF FINDINGS

Administrative Data

Date of Site-Visit:	Date of previous Site-Visit:	Name of Facility:
04/26/2017	10/18/2016	Central Arizona Florence Correctional Complex-East

Name of Reviewer:	Area of Responsibility/Field Office:
(b)(6); (b)(7)(C)	Phoenix Field Office

Accreditation Standard (check all that apply):

☐ NDS ☒ PBNDS 2008 ☐ PBNDS 2011 ☒ ACA ☒ NCCHC ☐ Other:

ICE Population Characteristics

Total ICE Population:	Male:	Female:	Transgender:	Pregnant:
505	505	0	0	0

Total Housed in Segregation:	Administrative:	Disciplinary:	Disabled:	Medical:	Mental Health:
5	4	1	0	0	0

Facility Administration

Health Services Administrator	Clinical Director
Name: (b)(6); (b)(7)(C)	Name: (b)(6); (b)(7)(C)
Email: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (520) 868-(b)(6); (b)(7)(C)	Phone Number: +1 (662) 345-(b)(6); (b)(7)(C)
Address: 1100 Bowling Road, PO Box 2667 Florence, AZ 85232	Address: 1100 Bowling Road, PO Box 2667 Florence, AZ 85232

Medical Care

☐ Compliant Non-Compliant with: ☒ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

CURRENT FINDINGS: One 2008 PBNDS deficiency
-Two detainees health assessments were not completed within 14 days of their arrival to the facility. One was completed 20 days after booking into the facility, and the other was completed 25 days after booking into the facility. Per PBNDS 2008, "Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition" (Medical Care) (V) (J).

PREVIOUS FINDINGS (October 2016): One 2008 PBNDS deficiency
-One detainee was at court on the day his health assessment was initially scheduled. The provider did not reschedule the health assessment; the health assessment was completed 22 days after booking (Medical Care) (V) (J).

Chronic Care *Enter all detainees with chronic conditions on the IGSA/CDF chronic care tracking sheet and submit with report.*

Total number with chronic conditions:	Total number with unstable chronic conditions:
45	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

POLICIES REVIEWED: Policy 13-06 "Chronic Care and Disease Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

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Hunger Strike

Total number on active hunger strike:	Total number of hunger strikes in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:

POLICIES REVIEWED: Policy 13-46 "Hunger Strikes" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted. FCC has not a had a detainee on hunger strike in the past year.

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Suicide Prevention and Intervention

Total number on suicide watch:	Total number of suicide watches in last 12 months:
1	63

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Terminal Illness, Advance Directives, and Death

Total number of active DNR cases:	Total number of deaths in last 12 months:
0	0

☒ Compliant Non-Compliant with: ☐ 1 – 2 Standards ☐ 3 Standards ☐ >3 Standards

Description of deficiencies:
POLICIES REVIEWED: Policy 13-03 "Advance Directives Living Will-Durable Power of Attorney for Health Care"

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted. There have been no reported deaths, detainees with terminal illness, or detainees with advance directives within the last 12 months.

Other Observations

This FMC site visit was conducted on April 26-28, 2017. The audit consisted of a review of 130 medical charts, sick call log, staff training binder, staff credential folders, the policy and procedure manual, and facility clinical protocols. The vast majority of medical charts reviewed were either active charts or charts of recently released detainees.

FACILITY DATA:
Central Arizona Florence Correctional Complex-East (CAFCC-East) is a non-dedicated contracted detention facility located in Florence, AZ. It is owned and operated by CoreCivic. The facility houses a combination of US Marshal (USM) inmates, ICE detainees, Material Witnesses (MWIT), and Bureau of Prison (BOP) inmates.

POPULATION CHARACTERISTICS:
Maximum Population- 1966 (886 ICE, 960 USM, 80 MWIT, and 40 BOP).
Current Population- 1239 (505 ICE, 689 USM, 24 MWIT, and 21 BOP).

ACCREDITATIONS/INSPECTIONS:
-The Nakamoto Group completed an audit of the facility on August 23, 2016 and found no deficiencies.
-ICE Office of Detention Oversite (ODO) completed an audit on June 30, 2016 and found no deficiencies.
-The American Correctional Association (ACA) completed an audit on April 6, 2016 and found no deficiencies.
-National Commission on Correctional Health Care (NCCHC) completed an audit on February 23, 2016 and found no deficiencies.

MEDICAL CLINIC/INFIRMARY:
The main medical unit has three exam rooms, a dental clinic, nurses station, and a laboratory room for specimen collection. A locked pharmacy and a locked medical records/supply room are located in main medical (facility utilizes electronic medical records). There are two negative pressure isolation rooms. There are three observation rooms, one of which is designated as a suicide observation room. Emergency equipment is located in the main medical department to include an emergency response bag, gurney, AED, portable suction, oxygen tank, and two eloctrocardiogram machines. Emergency equipment is checked twice a day by the nursing staff.

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CREDENTIALS:
Reviewed (b)(7)(E) There were no issues with the (b)(7)(E) files reviewed. Licensed personnel had current copies of licensing, and the staff had up-to-date BLS certification.

CURRENT MEDICAL STAFFING:

(b)(7)(E)

Deficiencies for Areas Evaluated

PBNDS 2008 DEFICIENCIES:
10% of health appraisals reviewed were completed greater than 14 days after arrival.

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Suicide Screening

POLICIES REVIEWED: Policy 13-84 "Suicide Management" is compliant with PBNDS 2008.

CAFCC-East performs suicide screening on all detainees that enter the facility. During the medical intake, all detainees are asked about current suicidal ideation and past suicide attempts.
CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

In the past twelve months there have been 63 detainees on suicide watch. Ten charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) suicidal patients were evaluated by the physician within 24 hours of identification.
-10 of 10 (100%) were evaluated by a qualified mental health professional every day.
-10 of 10 (100%) were monitored by a detention officer who documented every 15 minutes.

-In the ten charts reviewed, there is no evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Health Assessment

POLICIES REVIEWED: Policy 13-40 "Health Appraisals" is compliant with ICE PBNDS 2008.

Twenty charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-20 of 20 (100%) had an initial intake screening within 12 hours of booking.
-20 of 20 (100%) had a transfer summary with a chest x-ray report.
-4 of 4 (100%) received timely follow-up for significant findings of acute or chronic conditions.
-18 of 20 (90%) had a complete health evaluation completed within the first 14 days.

-At the time of this audit, all health appraisals are completed by either the NP or the physician.

PREVIOUS FINDINGS (October 2016): 1 of 10 (10%) health appraisals reviewed were done greater than 14 days from arrival.

CURRENT FINDINGS: 2 of 20 (10%) of health appraisals reviewed were done greater than 14 days from arrival.

Urgent Care (Sick Call)

POLICIES REVIEWED: Policy 13-80 "Sick Call" is compliant with PBNDS 2008.

According to the HSA, the sick call process is initiated by a detainee filling out a paper sick call request. Sick call is done seven days a week. A nurse picks up sick call requests daily, and they are addressed within 24 hours.

Ten urgent/sick call encounters were reviewed using the IHSC Quality of Care Audit Tool used to evaluate this area.
-10 of 10 (100%) charts reviewed had timely and appropriate evaluations by nursing staff, care delivered within the scope of the nurse's license, and vital signs were documented. Three detainees required a referral to MD/MLP with in 24 hours and had an MD/MLP/DMD documented assessment and plan.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Evaluation of Care Provider to ED/Hospital Visit for Conditions Sensitive to Ambulatory Care

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POLICIES REVIEWED: Policy 13-34 "Medical Emergency Response" is compliant with PBNDS 2008.

In the past six months, 6 detainees have been sent to an emergency department. All 6 charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-6 of 6 (100%) had an outbound progress note.
-0 of 6 (0%) showed evidence that earlier intervention might have prevented deterioration to the point of needing ED/hospital care.
-6 of 6 (100%) had discharge documentation from the hospital and an inbound assessment.

PREVIOUS FINDING (October 2016): No findings noted.

CURRENT FINDING: No findings noted.

Medication Administration Practices

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008.

-CAFCC-East currently uses electronic medication administration records. During direct observation, there was no evidence that staff was pre-pouring medication. Patient "medication administration rights" were observed, and at least two identifiers were in use, including the detainee armband scanner. The pharmacy storage area was inspected and was properly secured; refrigerator logs are maintained properly.

Ten medication administration records (MARs) were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-5% of the MARs reviewed contained blanks, consecutive refusals, or no shows. In every case a refusal form was completed.
-No MARs were found pending to be filed. FCC uses electronic medication administration records (Allscripts).
-Approximately 40% of patients are on self-administered medication ordered by a provider.
-Over the Counter (OTC) medications are provided by both medical and can be purchased at the commissary.
-None of the MARs reviewed had three consecutive days of refusals or 3 consecutive doses and or 4 or more doses in a week documented. A refusal form was completed on all refusals.

PREVIOUS FINDING (October 2016): No findings noted.

CURRENT FINDING: No findings noted.

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Continuity of Medication

POLICIES REVIEWED: Policy 13-70 "Pharmaceuticals" is compliant with PBNDS 2008.

When a detainee arrives to the facility with chronic medications, the intake nurse calls the on-call provider for orders/instructions. After reviewing the medication, the provider will provide a telephone order to continue the medication, if indicated. The medication is continued until the physical exam, at which time it is reordered as necessary.

Eight charts were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-8 of 8 (100%) charts showed that medications were ordered in less than 24 hours from completion of the intake.
-In 8 of 8 (100%) cases, the period of time from order to first dose was less than 24 hours.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Mental Health Screen

POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008.

All detainees are screened for mental illness as part of the medical intake. There are several questions that address mental illness including questions that specifically refer to suicide. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

Ten charts selected from the mental health caseload were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) with positive screens for mental illness were evaluated by a mental health professional in a timely manner. In the majority of cases, the evaluation occurred on the following clinic day.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Medical Recordkeeping Practices

POLICIES REVIEWED: Policy 13-58 "Medical Records" is compliant with PBNDS 2008.

CAFCC-East uses an electronic medical record system (Allscripts).

Ten charts were reviewed using the IHSC Quality of Care Audit Tool. No areas of concern were noted during reviews of medical records, facility processes, procedures and policy.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Pregnant Women

N/A. Females are not housed at the facility.

Dental Care

AMERICAN OVERSIGHT

POLICIES REVIEWED: Policy 13-13 "Dental Care" is compliant with PBNDS 2008.

CAFCC-East has a full-time dentist and a full-time dental assistant. All detainees receive a dental screening by the dentist within the first 14 days of detention. Other dental services are normally requested through a sick call request. The dentist evaluates the patient the following working day and decides if treatment is appropriate. The treatment is then scheduled.

Ten charts selected from the sick call log were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) were screened for symptoms during the intake process.
-10 of 10 (100%) were evaluated by a qualified health professional within 48 hours of the request.
-10 of 10 (100%) dental notes reviewed described findings, diagnosis, treatment, and plans.
-5 of 5 (100%) were scheduled for follow-up treatment as recommended.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

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Acute Laboratory Testing

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" is compliant with PBNDS 2008.

None of the charts reviewed contained STAT or acute lab work orders; however, ten contained completed routine lab work. The IHSC Quality of Care Tool was used to evaluate these records.
-0 of 10 (0%) had lab work collected within one day of the ordered date. All lab orders reviewed were considered routine and all were ordered during the initial chronic care appointment.
-10 of 10 (100%) were routine labs and had a report back and acknowledged within seven days.
-10 of 10 (100%) had an appropriate clinical response.
-10 of 10 (100%) patient charts reviewed had documentation that the patient was advised of the lab results.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Diagnostic Services and Specialty Care Access

POLICIES REVIEWED: Policy 13-31 "Diagnostic Services" and Policy 13-64 "Off Site Care and Consultations" is compliant with PBNDS 2008.

Ten charts were reviewed using the IHSC Quality of Care Audit Tool to evaluate this area.
-0 of 10 (0%) had a documented time urgency included on the order for specialty care although all ten had the appointment accomplished within 30 days of the order.
-10 of 10 (100%) had the appointment accomplished within 45 days of the order.
-10 of 10 (100%) had clinician acknowledgment for the specialist's report in the medical record within 7 days of the date the service was performed.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Mental Health Treatment Planning

POLICIES REVIEWED: Policy 13-61 "Mental Health Services" is compliant with PBNDS 2008.

Detainees are screened for potential mental health problems to include suicide risk and sexual/physical abuse history during the intake screening. Detainees who screen positive are referred to a mental health provider and are generally seen on the next day. CAFCC-East also performs a comprehensive mental health evaluation on all new detainees by a mental health provider within 7 days of booking into the facility.

Eight records out of the active mental health case load were reviewed using the IHSC Quality of Care tool.
-8 of 8 (100%) had a clinical assessment, treatment, and follow-up plan documented.
-8 of 8 (100%) patient reviewed had a treatment plan updated at a minimum of every 90 days.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Treatment of Disability

POLICIES REVIEWED: Policy 13-82 "Special needs Treatment Plans" is compliant with PBNDS 2008.

At the time of this audit, there was only one detainee documented to have a disability. This record was reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-The facility maintains a list of all patients with disabilities.
-1 of 1 (100%) had the disability prominently displayed in the medical file.
-1 of 1 (100%) was assessed for assistance of activities of daily living (ADL) upon identification of disability and appropriate accommodation orders were entered.

PREVIOUS FINDINGS (October 2016): No findings noted.

AMERICAN OVERSIGHT

CURRENT FINDINGS: No findings noted.

Complaints and Grievances

POLICIES REVIEWED: Policy 13-08 "Complaint Resolution" and Policy 14-05 "Inmate-Resident Grievance Procedures" is compliant with PBNDS 2008.

According to the CoreCivic grievance officer, all dorms have access to grievance forms and a drop box labeled for this purpose. The grievance officer picks them up and reviews them daily. All medical grievances are then given to the Provider Coordinator in medical and reviewed. The Provider Coordinator is then responsible for answering all medical grievances within 5 business days.

Five charts were reviewed using IHSC Quality of Care Audit Tool to evaluate this area.
-A total of 7 grievances were submitted over the past 3 months.
-All seven grievances were addressed within 5 working days of receipt.
-4 of the 7 requests were related to delays in care, 2 were related to attitude, demeanor or conduct of staff and one was related to denial or refusal of specific request for care.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

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Diabetes

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" is compliant with PBNDS 2008.

Ten diabetic medical records were reviewed using the IHSC Quality of Care Tool designed for this purpose.
-10 of 10 (100%) had a blood sugar measured at intake.
-10 of 10 (100%) were seen for chronic care by a medical provider within 14 days.
-10 of 10 (100%) had a baseline HgbA1C performed within the first 30 days.
-9 of 9 (100%) had lipids measured within one year.
-9 of 9 (100%) were followed at least every 90 days with appropriate vital signs.
-3 of 3 (100%) had aspirin prescribed when indicated.
-10 of 10 (100%) had a degree of control (goal HgbA1C<8.0) documented.
-6 of 6 (100%) had a strategy to attain diabetes control documented when HgbA1C was above goal.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Human Immunodeficiency Virus (HIV)

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" is compliant with PBNDS 2008.

At the time of this audit, CAFCC-East had only one ICE detainee documented as having HIV, and he was transferred to USM custody 7 days after arrival to the facility. This chart was reviewed using IHSC Quality of Care Audit Tool to evaluate this area.
-HIV was identified by the available medical records upon transfer to the facility.
-Detainee was only in ICE custody for 7 days; therefore, the other measures were N/A.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDING: No findings noted.

Hypertension

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" is compliant with PBNDS 2008.

10 charts of hypertensive patients were reviewed using the IHSC Quality of Care Audit Tool designed for this purpose.
-10 of 10 (100%) had a documented blood pressure on the medical intake.
-10 of 10 (100%) patients were seen by a medical provider within the first 14 days of arrival at the facility.
-5 of 5 (100%) revealed intake blood pressures that had systolic blood pressure greater than 140 or a diastolic pressure greater than 90. In all five (100%) medical records there was documentation that the nurse called and received a treatment plan from the provider which included medication and blood pressure monitoring.
-In 9 of 9 (100%) cases, it appeared that a chronic disease guideline for HTN, which included obtaining baseline lab work, was followed.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

Asthma

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" is compliant with PBNDS 2008.

Six charts of asthma patients were reviewed using the IHSC Quality of Care Audit Tool

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prescribed for use in this area.
-6 of 6 (100%) were seen for chronic care by a medical provider within 14 days of illness identification.
-6 of 6 (100%) had a peak flow measurement completed both during the physical exam and when seen for chronic care.
-6 of 6 (100%) followed a chronic disease guideline which addressed disease severity, prescription of medication consistent with severity, and documented degree of control.

PREVIOUS FINDINGS (October 2016): Peak flow measurements were not recorded within the physical exams of asthmatic detainees. The peak flows were being completed at the chronic care appointment.

CURRENT FINDINGS: No findings noted.

Seizure Disorder

POLICIES REVIEWED: Policy 13-06 "Chronic Care Disease Management" is compliant with PBNDS 2008.

At the time of this audit, FCC had only one ICE detainee documented as having Seizure Disorder. This chart was reviewed using the IHSC Quality of Care Audit Tool prescribed for use in this area.
-1 of 1 (100%) had an appropriate neurological assessment completed at the initial physical exam.
-1 of 1 (100%) was seen by a medical provider within 14 days of illness identification.
-1 of 1 (100%) had serum drug levels performed and acknowledged at least every 3 months until stable.
-1 of 1 (100%) had an established treatment plan.
-1 of 1 (100%) had orders for a bottom bunk.

PREVIOUS FINDINGS (October 2016): No findings noted.

CURRENT FINDINGS: No findings noted.

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Recommendations

(b)(7)(E)

Facility Actions

The HSA, Clinical Supervisor, Program Manager and the facility Warden were notified of all findings/deficiencies during a close-out interview. The Florence Assistant Field Office Director (AFOD) was given a summary of findings via telephone.

Additional Comments

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End of Report

IHSC, Field Medical Coordinator	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 210-(b)(6); (b)(7)(C)	Date Prepared: 05/05/2017
IHSC, Regional Field Medical Coordinator ☒ **West** ☐ **East**	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)	Date Reviewed: 06/19/2017
IHSC, Chief, Medical Case Management Branch	
Name: (b)(6); (b)(7)(C)	Email: (b)(6); (b)(7)(C)
Phone Number: +1 (202) 732-(b)(6); (b)(7)(C)	Date Approved:
IHSC, Headquarters	
Name: (b)(6); (b)(7)(C)	Title: Western Regional FMC
Email: (b)(6); (b)(7)(C)	Phone Number: +1 (949) 360-(b)(6); (b)(7)(C)
Signature: (b)(6); (b)(7)(C)	**Final Approval Date:** 06/19/2017

Recommendations:

(b)(5)

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U.S. Immigration and Customs Enforcement

IHSC Health Systems Assessment - Report Complete

Facility	Eloy
Start Date	2017-06-11
End Date	2017-06-21
Status	Report Complete
Corrective Action Required?	Pending Determination
On-Site Corrective Actions	None Identified

Health Systems Assessment Team

Team Lead	(b)(6); (b)(7)(C)
Pre-Audit Reviewers	(b)(6); (b)(7)(C)
On-Site Reviewers	
Post-Audit Reviewers	NaN
Specialist, MQMU	(b)(6); (b)(7)(C)

Headquarters Review

Chief, Health Operations Unit Review Status	Review Deferred (Team Lead Only)
Chief, Medical Quality Management Unit Review Status	Review Complete
DAD, Administration Review Status	Review Deferred (Team Lead Only)
DAD, Clinical Services Review Status	Review Complete
DAD, Health Care Compliance Review Status	Review Deferred (Team Lead Only)
DAD, Health Systems Support Review Status	Review Deferred (Team Lead Only)
Chief of Staff Review Status	Review Deferred (Team Lead Only)
AD, IHSC Review Status	Review Complete

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Facility Information - Review Complete

Facility HSA	(b)(6); (b)(7)(C)
Regional HSA	
Bed Capacity	1550.00
MHU Beds	2.00
Daily Adult Male Population	963.00
Daily Adult Female Population	356.00
Daily Juvenile Male Population	0.00
Daily Juvenile Female Population	0.00
Average Length of Stay (Days)	81.00
Comments	(b)(7)(E) (b)(7)(E) Accreditation requires MHU rooms to be within sight or sound of a medical staff member, not custody staff. Additionally, the make shift MHU that is used to house medical patients is in a separate building from medical and is not staffed with medical personnel. Recommend (b)(5); (b)(7)(E)

Average Number of Encounters (Past 3 Months)

Prescreenings	521.00
Intake Screenings	516.00
Physical Examinations	435.00
Vitals/Labs	506.00
Sick Call	871.00
Pros/Imm	282.00
Acute	368.00
Chronic	144.00
Mental Health	527.00
Dental	145.00
Emergent/Urgent	394.00

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MHU	366.00
Segregation	824.00
Admin	130.00
Transfers	355.00
Pill-Line Passes	3757.00
Prescriptions (Pill-line + KOP)	8086.00
Referrals/ER	181.00
Comments	NO DATA

Staffing Information - Review Complete

(b)(7)(E)

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Accreditation - Review Complete

Last ACA Accreditation	2015-03-09
Last ACA Findings	None
Last NCCHC Accreditation	2015-03-23
Last NCCHC Findings	On their initial report from their last NCCHC survey, Eloy was found non-compliant in the following: There are 40 essential standards; 39 are applicable to this facility and 37 (95%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. Our findings include: Essential Standards Not in Compliance J-A-06 Continuous Quality Improvement Program J-A-07 Emergency Response Plan Essential Standard Not Applicable J-G-03 Infirmary Care There are 27 important standards; 26 are applicable to this facility and 25 (96%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. Our findings include: Important Standard Not in Compliance J-A-10 Procedure in the Event of ari Inmate Death Important Standard Not Applicable J-C-08 Health Care Liaison J-A-06 Continuous Quality Improvement Program (E). The CQI program identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. The quality improvement committee, which meets quarterly, includes the participation of the responsible physician or mid-level providers as his designee, HSA, physician assistants, nurse practitioners, mental health representatives, and CQI nurse. The committee identifies problems, establishes thresholds, designs monitoring activities, analyzes the results and remonitors performance after implementing improvement strategies. Several studies have been completed since the last survey. Recent studies examined the effectiveness of suicide identification which were started in February 2015 and were not yet completed at the time of the survey. Studies for 2014 focused on chronic care charting, evaluation of HIV care and treatment, general chronic care, and urgent care review. Process studies include ongoing tracking and monitoring of screenings, evaluations and response to requests and triage. Physician participation in CQI efforts was evident. However, there was no evidence of annual reviews of the CQI

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program. The standard is not met 4 Corrective action is required for Compliance Indicator #5. The committee should complete an annual review of the effectiveness of the CQI program as required by the standard. Documentation is required to demonstrate that a plan is in place to correct all aspects of this standard. Acceptable documentation includes a copy of written policy and defined procedures for the CQI program, including provisions for annual reviews of its effectiveness. In order to receive accreditation, verification that this standard has been met is required. In order to receive accreditation, verification that this standard has been met is required. J-A-07 Emergency Response Plan (E). The RHA and facility administrator have approved the health aspects of the emergency response plan, which includes all the required elements. The mass disaster drill scenarios included a detainee fight in a pod, a power outage, and a hostage situation. The drills have been critiqued and the results were shared with the health staff, both verbally and in writing. Man-down drills have been held so that health staff on each shift has been able to participate annually. At this facility, three man-down drills per month have been well documented. The man-down drills/events have also been critiqued and the results shared with all health staff. However, over the course of three years, not all staff has had an opportunity to participate in a mass disaster drill. Drills have been held annually, but have combined two shifts either in the morning or in the afternoon. We emphasized that the drill for 2015 should include staff on the night shift. The standard is not met. Corrective action is required for Compliance Indicator# 2. At least one mass disaster drill should be conducted annually so that over a three-year period, each shift has participated. Practicing the emergency response plan makes health staff better able to respond to disasters when they occur in order to protect the health, safety, and welfare of inmates, staff, and visitors. Acceptable documentation includes 1) a copy of the critique of a mass disaster drill for night shift, with evidence that the results have been shared with all health staff; and 2) a copy of a plan by the RHA that addresses how mass disaster drills will be conducted annually in the future. In order to receive accreditation, verification that this standard has been met is required. The facility was re-accredited after

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	submitting the requested verification of compliance with the standards.
Last PBNDS Accreditation	2017-01-31
Last PBNDS Findings	No medical findings on last PBNDS visit
Comments	NO DATA

Grievances - Review Complete

Number of medical grievances reported through QI/JIC/CRCL/DRIL	1.00
Is there a local SOP for managing grievances?	No - See findings below.
Is there an identified grievance officer?	Yes
Is there a log book and is it up to date?	Yes
Number of medical grievances that were not addressed in a timely manner.	0.00
Number of formal grievances.	31.00
Number of informal grievances.	4.00
Findings	-Facility follows IHSC National Policy and PBNDS standards -Current practice: AHSA is G.O. and addresses initial grievances directly. Appeal is referred to HSA to address.
Deliverables	(b)(5)

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Risk Management - Review Complete

Trends	(1) RCA involving medical care management of detainee with alcohol and opioid withdrawal. (1) RCA involving care management of detainee with medical issues not addressed.
Number of active RCAs/SOEs	2.00
Number of RCAs or SOEs completed during the last six (6) months.	0.00
Number of corrective actions generated from RCAs or SOEs during the last six (6) months.	0.00
List all corrective actions identified in the preceding field and note their status and due dates.	NO DATA
Findings	NO DATA
Deliverables	NO DATA

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Medication Administration - Review Complete

Is pre-pouring occuring?	No - See findings below.
Are nurses adhering to the six rights of medication administration (right patient, right drug, right route, right dose, right time, and right documentation)?	Yes
Are nurses using two forms of identification prior to administration?	No - See findings below.
Are mouth checks being conducted with every administration?	Yes
Are nurses administering only medications that they prepare?	Yes
Are all entries in the MAR complete (allergies, staff initials, etc)?	Yes
Number of all medication refusals documented on the MAR.	10.00
Of the identified medication refusals from the MAR, how many refusals did not have accompanying eCW documentation?	0.00
Number of high risk medication refusals.	0.00
Of the identified high risk medication refusals, how many times were providers NOT notified of the refusal?	0.00
Are nurses documenting the medication administration immediately after the medication is administered?	Yes
Findings	-CCA only issues an ID, no wrist bands. Nurses were only using ID and not a second source of ID. Recommended asking detainee to confirm their name as second source. Staff implemented immediately. -Sampled MARs for refusals: Found 10 - Documentation complete -Staff reported for every refusal they send the provider a TE -The structural set up for pill line forces the need for two nurses to conduct pill line even though the number of medications to be passed could be accomplished by one. -CCA process for getting detainees to pill line is to have them go to eat first, then as they finish eating and depart the cafeteria, they come to the pill line window. This results in a inefficient use of resources as the nurses have significant down time waiting for detainees to report to the pill line. Additionally, the CCA officers working the pill line do

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	not prevent other detainees from coming to the window regardless if they are on the list provided for that pill pass. -The staff shared that due to the current process there are times they go over the two hour zone for administering medications.
Deliverables	-Suggest Medical inform detainees of need to confirm their ID with two forms of ID in order to help facilitate compliance and inform CCA staff that work pill line for the same reasons. -Suggest working with CCA to develop a more efficient process for getting detainees to and through pill line.

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Emergency Preparedness and Response- Review Complete

Is there documentation of the man-down drills on each shift (once per month), mass casualty drills, and fire drills that have been conducted?	Yes
Do emergency scenarios vary?	Yes
Is the difference between a drill and an actual event evident in the write-up?	Yes
Do all staff participate in the drills?	No - See findings below.
Are all staff trained on emergency equipment?	Yes
Is emergency equipment checked daily and documented?	Yes
Is there documentation to support the training?	Yes
Did all staff receive an "after-action" debriefing?	No - See findings below.
If mortality related response, did staff involved submit a sequence of events statement of occurrence within 24 hours of incident and offered any adjustment support?	No - See findings below.
Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	No - See findings below.
Findings	-Staff who are on the shift participate in the drill but not all staff who work in medical are able to participate as some are off that day. There was no mechanism to disseminate the drill findings with staff who were not participating in the drill. Additionally a drill is different from a training evolution. A drill should replicate how you actually respond to an event in order to identify issues with the response. Training evolutions are to train staff, drills are to identify issues in the response that should subsequently be covered in training. This is not to say that training cannot be done during drills but at the same time, a drill should only include those resources used to normally respond to a drill. - Staff present participated in after action. - Had documentation on debriefing but no memo's from staff who were involved in detainee's death. IHSC does not have a policy on what actions are necessary following the death of a detainee. - Contact information is included in all charts but does not have a date indicating when it was last updated. - Staff on evening and night shifts were not assigned on a ERT.

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Deliverables	(b)(5)

Environmental Health - Review Complete

Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	Yes
Are hazardous chemicals (including cleaning supplies) labeled and securely stored?	Yes
The Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, and annual checklists are completed, signed by the HSA or designee, and maintained locally.	Yes
Items not in compliance with the Public Health, Safety, and Preparedness Toolkit daily, weekly, monthly, quarterly and annual checklists are documented to show corrective action with the completion date.	Yes
Are all airborne infection isolation (AII) room doors labeled "restricted area" and include requirements for entry?	Yes
Is documentation of daily checks on AII rooms' negative pressures complete?	Yes
Is the OSHA Form 300A summary completed and posted in clinic from Feb 1st through April 30th each year?	Yes
Findings	No Findings - System is well organized and well maintained.
Deliverables	NO DATA

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Consent Forms - Review Complete

Number of consent forms reviewed.	25.00
Number of consent forms that were complete (not missing detainee signature, witness, or date).	25.00
Number of dental consent forms among the identified consent forms.	3.00
Number of dental consent forms that were complete (missing detainee signature, witness, or date).	3.00
Number of psychotropic consent forms among the identified consent forms.	2.00
Number of psychotropic consent forms that were complete (not missing detainee signature, witness or date).	2.00
Number of consent forms completed by a staff member other than the one completing the intake encounter.	0.00
Among the consent forms completed by a staff member other than the one completing the intake encounter, how many addressed the use of translation?	0.00
Findings	NO DATA
Deliverables	NO DATA

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Transfers - Review Complete

Number of transfers reviewed.	25.00
Number of transfers authenticated appropriately (signed, stamped, and dated).	25.00
Number of transfers initiated in eCW.	25.00
Number of transfers completed by LVN or above.	25.00
Number of transfers with TB clearance annotated correctly.	22.00
Out of the transfers reviewed, how many had a positive chest X-ray?	1.00
Out of the transfers with positive chest X-ray, how many had lab results documented to verify non-infectiousness?	1.00
Out of the transfers reviewed, how many have active TB?	0.00
Out of the transfers with active TB, how many are not being treated for TB?	0.00
Number of transfers with chronic medical conditions or lack thereof annotated.	7.00
Number of transfers with medication instructions clearly provided.	7.00
Number of transfers signed by a proper level provider.	25.00
Findings	(b)(6); (b)(7)(C) Transfer summary missing prior CXR results conducted on 01/24/16 with negative results. (b)(6); (b)(7)(C) Transfer summary "TB Screening Modality" is documented "Symptom Screening" Should document modality of CXR from 03/15/17 with negative results (b)(6); (b)(7)(C) TB suspect: Transfer summary question "Is the detainee/resident being teated for active TB Disease? Transfer summary indicates "No Patient started on RiPE Therapy on 04/27/2017. Smear negative X3, cultures pending X3". Should state "Yes".
Deliverables	NO DATA

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Prescreening Review - Review Complete

Number of prescreens reviewed.	25.00
Number of prescreens with detainee identified with at least two detainee identifiers.	22.00
Number of prescreens triaged according to prescreen policy.	25.00
Number of prescreens that used a translator.	4.00
Of the prescreen records that used a translator, how many listed a translator name or ID number?	4.00
Of the prescreen records that did not use a translator, how many listed a reason for not using a translator?	15.00
Number of prescreens with documentation completed in eCW prior to intake screening.	0.00
Findings	Documentation for nine (9) pre-screenings completed in e-CW, after the intake screenings For three (3) pre-screenings reviewed, only one source for properly identifying the detainee was listed, and that was verbally. No second source for identifying detainee was listed. For six (6) pre-screening charts reviewed, no reason was listed for why an interpreter was not utilized. Only the fact that one was not utilized.
Deliverables	NO DATA

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Prescreening Observations - Review Complete

Number of prescreen encounters observed.	15.00
Number of prescreen encounters observed that allowed for patient privacy.	15.00
If privacy was not provided, where was the prescreen performed?	NO DATA
Number of prescreen encounters that used language services.	2.00
Number of prescreen encounters completed within two hours of arrival.	15.00
Number of prescreen encounters documented in eCW prior to initiation of intake screening.	15.00
Number of prescreen encounters prioritized.	4.00
Of the prescreen encounters prioritized, how many were referred to intake in a timely manner?	4.00
Findings	In the anteroom entering the facility where the prescreening are conducted, there is no phone, which requires prioritizing all who need an interpreter. This results in the prescreening process taking longer and prioritizes them equal to those with medical issues. Current intakes are approximately 30 per day and are manageable using this process.
Deliverables	(b)(5)

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Intake Screening Review - Review Complete

Number of intake screenings reviewed.	25.00
Number of intake screenings with detainee identified with at least two detainee identifiers.	25.00
Of the intake records reviewed, how many used a translator?	8.00
Of the intake screening records that used a translator, how many listed a translator name or ID number?	8.00
Of the intake screening records that did not use a translator, how many listed a reason for not using a translator?	17.00
Number of notes with TB clearance noted (PPD, CXR, current CXR from other facility).	25.00
Of the intake screening records, how many were TB negative?	25.00
Of the intake screening records that are TB negative, how many were signed, dated, and stamped by an RN or above?	18.00
Of the intake screening records, how many were TB positive?	0.00
Of the intake screening records that are TB positive, how many were signed, dated, and stamped by an RN or above?	0.00
Number of intake screenings with a complete pain assessment using the pain scale indicator.	25.00
Number of intake screenings with pain scale greater than 0.	2.00
Of the intake screenings with a pain scale greater than 0, how many were addressed?	1.00
Number of intake screenings with mental health screening completed.	25.00
Number of intake screenings that used the eCW Intake Screening template.	25.00
Of the intake screenings that used the eCW Intake Screening template, how many were completed appropriately (i.e., default answers changed to reflect the patient's response)?	25.00
Number of intake screenings with clinically significant findings.	7.00

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Of the intake screenings with clinically significant findings, how many were referred appropriately?	6.00
Number of intake screenings reviewed by an RN or above within 24 hours.	3.00
Findings	Detainee not referred appropriately for findings discovered during Intake. Detainee expressed they were in pain 5/10. "I feel bad. I have a stomahache." The detainee indicated they had their gallbladder removed 3 months prior. Since that time, they have had pain, vomitting, and epigastric pain.Was hospitalized for UTI 6 months ago. The detainee's Intake was still coded as Normal and they were scheduled for a PE-S. The detainee was listed as being in 0/10 pain under vital signs section despite detainee stating they were in 5/10 pain. Detainee's blood pressure at Intake listed as 140/88. Intake screening coded as normal and there is no mention of the elevated BP reading within the Intake documentation. Detainee scheduled for PE-S. Detainee's BP further elevated at 154/93 during the PE-S, and a telephone encounter was done then, for the detainee to have BP checks. Evidence of TB clearance is in chart; however, negative TB screening not signed, dated, stamped by RN or higher (Note: Please refer to Eloy's Excel Tracker Sheet for the Alien numbers associated with above.)
Deliverables	NO DATA

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Intake Screening Observations - Review Complete

Number of intake screenings observed.	6.00
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initating the intake screening.	6.00
Number of intake screening observations where a full set of vital signs were taken.	6.00
Number of intake screening observations that used language services.	2.00
Of the intake screening observations that used language services, how many were appropriately conducted?	2.00
Number of intake screenings observations documented in eCW within one hour of the evaluation.	6.00
Number of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and the grievance process.	6.00
Number of intake screening observations with security advice of special needs and housing disposition.	0.00
Of the intake screening observations with security advice, how many contained clear communications?	0.00
Findings	Nursing staff conducting intake screenings were polite and professional with each detainee. The system is efficient and conducted in collaboration with ICE and CCA, ensuring all stakeholders meet their mission in a timely manner.
Deliverables	(b)(5)

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Chronic Care Review - Review Complete

Number of chronic care encounters reviewed.	25.00
Number of chronic care encounters with appropriate referrals based on category and severity.	25.00
Number of chronic care encounters with a PE-C completed within 48 hours.	21.00
Number of chronic care encounters with chronic condictions properly document in eCW Problem List (e.g., asthma, hypertension, etc).	25.00
Number of chronic care encounters with medications.	24.00
Of the chronic care encounters with medications, how many were provided or continued appropriately?	22.00
Number of chronic care encounters with psychiatric medications.	5.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or MLP every 30 days for medication assessment or review?	5.00
Of the chronic care encounters with psychiatric medication, how many encounters indicated that the detainee was seen by an MD or psychiatrist every 90 days?	5.00
Number of chronic care patients identified as stable.	25.00
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	25.00
Number of chronic care patients identified as unstable.	0.00
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	0.00
Number of chronic care encounters where a global alert (IHSC 834 or electronic equivalent) was completed.	24.00
Number of chronic care encounters where baseline medical data was document on form IHSC 847 or electronic equivalent.	0.00

Findings

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	(b)(5) (b)(5) 2) Incidental/best practice findings: Pt with Hypotension/abnormal vitals not addressed 3) Best practice concern/finding: One chart intake on 4/3/17 bp: 180/104, provider notified no medications ordered/given only daily bp checks x few days and pt scheduled and seen by a Provider as PE-S on 4/10/17. 4) Best practice recommendations: Peak Flow should be documented for Asthmatic pt during chronic care f/u 5) Best practice recommendations: Hypertriglycemia (trilycerides 455) not addressed
Deliverables	NO DATA

Chronic Care Observations - Review Complete

Number of chronic care encounters observed.	4.00
Number of chronic care encounters observed that utilized language services.	0.00
Number of chronic care encounters observed that were completed within the timeframe indicated by a previous visit (90 days for stable intake screening or stable prior chronic care visit, >90 days for unstable patients).	4.00
Findings	No issues noted. Providers did a good job of educating the detainees.
Deliverables	NO DATA

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Physical Examinations Review - Review Complete

Number of physical examinations reviewed.	25.00
Number of physical examinations reviewed that used language services.	12.00
Of the physical examinations that used language services, how many contained identification of the translator/interpretter (name, ID, etc)?	12.00
Number of physical examinations reviewed for juveniles.	0.00
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	0.00
Number of physical examinations reviewed for adults.	25.00
Of the physicial examinations for adults, how many were completed within 14 days of arrival to the facility?	25.00
Number of physical examinations with pain assessment.	25.00
Of the physical examinations with pain assessment, how many were addressed?	25.00
Number of physical examinations with clinically significant findings.	20.00
Of the physical examinations with clinically significant findings, how many had a plan to address them?	20.00
Number of physical examinations reviewed by an MD (PE-C within 7 days; PE-S within 14 days).	25.00
Number of physical examinations for females.	7.00
FEMALE ONLY - Number of physical examinations with a record of the last menstrual cycle.	7.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter.	3.00
FEMALE ONLY - Number of physical examinations with a last menstrual cycle greater than 45 days prior to the encounter with appropriate documentation.	3.00
FEMALE ONLY - Number of physical examinations with a pap test offered.	0.00

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FEMALE ONLY - Number of physical examinations where a pap test was not indicated.	5.00
FEMALE ONLY - Number of physical examinations where a pap test was not indicated with appropriate documentation.	1.00
Findings	1) Best practice finding/recommendations: GYN section not documented for for female patients which would shed light as to if pap test would be clinically inidicated 2) Best practice finding/recommendation: In one chart intake note was merged into the PE-C note instead using the PE Smart form 3) Incidental/Best practice finding: One Chart Pt was started on Antipsychotic medication on 5/14/17 and no notification noted to alert MLPs that this pt now needs monthly Chronic f/u with a MLP per policy (b)(5) (b)(5) Also no baseline AIMS test noted on file as required by policy.
Deliverages	NO DATA

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Physical Examinations Observations - Review Complete

Number of physical examination encounters observed.	7.00
Number of physical examination encounters with a full set of vital signs taken.	7.00
Number of physical examination encounters observed that were completed within 14 days.	7.00
Number of physical examinations that offered a chaperone.	
Of the physical examinations that offered a chaperone, how many accepted?	0.00
Of the physical examinations with a chaperone, how many contained documentation of the chaperone's name?	0.00
Of the physical examinations that offered a chaperone, how many refused?	0.00
Of the physical examinations that refused a chaperone, how many contained appropriate documentation of refusal?	0.00
Findings	PE's were all completed within the 10 day time frame. Detainees were educated about the process, interpreters were used with 4 of the PEs, as these were the only times it was required. Detainees were also educated on preventive health issues. Additionally, detainees were appropriately referred when a medical issue was noted during the PE-S for a PE-C. - Nurses are using paper to perform PEs and then going back and documenting them after the completion of PEs.
Deliverables	(b)(5)

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Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

					*Indicates Required Field	
Facility Information						
Facility Name:*	STWRTGA19- Stewart Detention Center					
AOR:*	ATL					
Address:	146 CCA Road					
City:	Lumpkin		**County:**	Stewart		
State:*	GA	**Zip:**		31815		
Inspection Information						
Start Date:*	5/7/2019					
End Date:*	5/9/2019					
Organization:*		Other				
# Detainees at Time of Visit:		1874				
Total Facility Population at Time of Visit:		1874				
Facility Capacity:		1924				
Notes:						
Reviewer Information						
Lead Reviewer Name:*	b(6), b(7)(c)			**Date Signed:***	5/9/2019	
Signature:	X					
HQ Use Only:				*1/3/2019*		

AMERICAN OVERSIGHT

	A	B	C	D
1		**Compliance Dashboard**		
2	**Subject Area**	**Description**	**Compliance**	
3	ASM	Asthma	75%	
4	CG	Complaints and Grievance	13	*Total Number
5	CM	Continuity of Medications	100%	
6	DC	Dental Care	100%	
7	DM	Diabetes	84%	
8	DSA	Diagnostic Services and Specialty Care Access	100%	
9	EED	Evaluation of Care Prior to Emergency Department	100%	
10	HA	Health Assessment	98%	
11	HIV	Human Immunodeficiency Virus	100%	
12	HTN	Hypertension	75%	
13	LT	Laboratory Testing	100%	
14	MR	Medical Recordkeeping	100%	
15	MAR	Medication Administration Records		
16	MHS	Mental Health Screen	100%	
17	MHT	Mental Health Treatment Planning	100%	
18	PG	Pregnant Women		
19	SZ	Seizure Disorder	87%	
20	SS	Suicide Screening	100%	
21	TD	Treatment of Disability	79%	
22	UC	Urgent Care (Sick Call)	100%	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**IGSA STAFFING MATRIX**			
2							**1 FTE = 40 hours / per week*
3							
4	**Position**	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
5							
6	**C.N.A.**						
7	**Dental Assistant**						
8	**Dentist**						
9	**EMT**						
10	**H.S.A.**						
11	**LVN/LPN**						
12	**MH Counselor**						
13	**MRT**						
14	**NP/PA**						
15	**Nurse Manager**						
16	**Paramedic**						
17	**Pharmacist**						
18	**Pharmacy Tech**						
19	**Physician**						
20	**Psychiatrist**						
21	**Psychologist**						
22	**RN**						
23	**Social Worker**						
24	**X-ray Tech**						
25	**Other 1**						
26	**Other 2**						
27							
28	**TOTAL**	0	0	0	0	0	0

AMERICAN OVERSIGHT

	A
1	
2	
3	**INTRODUCTION TO THE QMC**
4	These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc. Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.
5	• These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
6	• The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
7	• The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.
8	• The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody ≥ 14 days.
9	• In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
10	• While the goal is 100% compliance, the performance objective for most of the audit tools is ≥ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
11	• The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
12	• In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.
13	
14	**AUDIT TOOL COMPLETION**
15	Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer. Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.
16	
17	**TIPS FOR REVIEWERS**
18	• Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

AMERICAN OVERSIGHT

	A
19	• Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.
20	• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
21	• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
22	• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
23	• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
24	• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
25	• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
26	• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
27	• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

	A	B	C
1	**Term**	**Description**	
2	A#	Enter A# in format 123456789. Omit all leading characters such as "A".	
3	N/A - LOS	N/A Due to Length of Stay	
4	N/A - NLOS	N/A Not Due to Length of Stay	
5	ASM	Asthma	
6	CG	Complaints and Grievance	
7	CM	Continuity of Medications	
8	DC	Dental Care	
9	DM	Diabetes	
10	DSA	Diagnostic Services and Specialty Care Access	
11	EED	Evaluation of Care Prior to Emergency Department	
12	HA	Health Assessment	
13	HIV	Human Immunodeficiency Virus	
14	HTN	Hypertension	
15	LT	Laboratory Testing	
16	MR	Medical Recordkeeping	
17	MAR	Medication Administration Records	
18	MHS	Mental Health Screen	
19	MHT	Mental Health Treatment Planning	
20	PG	Pregnant Women	
21	SZ	Seizure Disorder	
22	SS	Suicide Screening	
23	TD	Treatment of Disability	
24	UC	Urgent Care (Sick Call)	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1	**ASTHMA (MODERATE AND SEVERE)**								
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs (Medical Administrative Record).							
6	**Sample:**	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
7		NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Guidelines:**	National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3.							
10		https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf							
11		Peak Expiratory Flow Rates, (Sept, 2016)							
12		http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
13	**Remarks:**			Peak Flow are not conducted at the initial physical exam					
14	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**			5/9/2019	
15									
16				**Facility (f)**					
17	**fASM-1a:**	Does the facility follow a particular clinical practice guideline to manage asthma?						Y	
18	**~~fASM-1b:~~**	~~If yes, what is the guideline?~~			~~BOP Clinical Practice Guidelines~~				
19									
20									
21				**Clinical (c)**					
22	**cASM-1**	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cASM-2**	Was a peak flow completed at the initial physical exam?							
24	**cASM-3**	Was a peak flow completed at the CC visit or within the last 3 months?							
25	**cASM-4**	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
26									
27	**Totals:**		9	0	9	9			
28	**Total Applicable:**		10	10	10	10			
29	**Total Met:**		10	0	10	10			
30	**% Compliance:**	75%	100%	0%	100%	100%			
31				**A#**					
32	**Patient(s)**	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
33	1	b(6), b(7)(c)	Yes	No	Yes	Yes			
34	2	b(6), b(7)(c)	Yes	No	Yes	Yes			
35	3	b(6), b(7)(c)	Yes	No	Yes	Yes			
36	4	b(6), b(7)(c)	Yes	No	Yes	Yes			
37	5	b(6), b(7)(c)	Yes	No	Yes	Yes			
38	6	b(6), b(7)(c)	Yes	No	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
39	7	b(6), b(7)(c)	Yes	No	Yes	Yes			
40	8	b(6), b(7)(c)	Yes	No	Yes	Yes			
41	9	b(6), b(7)(c)	Yes	No	Yes	Yes			
42	10	b(6), b(7)(c)	Yes	No	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1					**DIABETES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3					10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with diabetes chosen at random, if available.							
7	**Guidelines:**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Remarks:**		Per the Regional Medical Director, the local policy of initial chronic care clinic is 30 days after intake process.						
10	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
11									
12					**Facility (f)**				
13	**fDM-1:**	What clinical practice guideline does the					BOP Clinical Practice Guidelines		
14		facility use to manage diabetes?							
15									
16					**Clinical (c)**				
17	**cDM-1**	Was blood sugar measured and recorded on intake?							
18	**cDM-2**	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable pa medications (4 or more) should be seen sooner.)							
19	**cDM-3**	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?							
20	**cDM-4**	Were lipids measured within one year?							
21	**cDM-5**	Was patient followed at least every 90 days with appropriate vital signs?							
22	**cDM-6**	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.							
23	**cDM-7**	Was degree of control (goal HgbA1C <8.0) documented?							
24	**cDM-8**	Was a strategy to attain diabetes control documented if HgbA1C was above goal?							
25									
26	**Total Applicable:**		10	9	8	7	3	4	8
27	**Total Met:**		9	3	8	7	3	3	7
28	**% Compliance:**	84%	90%	33%	100%	100%	100%	75%	88%
29					**0**				
30	**Patient(s)**	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**
31	1	b(6), b(7)(c)	No	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS	N/A - LOS
32	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
33	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
34	4	b(6), b(7)(c)	Yes	Yes	Yes	N/A - LOS	N/A - LOS	N/A - NLOS	Yes
35	5	b(6), b(7)(c)	Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	No
36	6	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	N/A - NLOS	Yes
37	7	b(6), b(7)(c)	Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	N/A - LOS
38	8	b(6), b(7)(c)	Yes	No	N/A - LOS	N/A - LOS	N/A - LOS	No	Yes
39	9	b(6), b(7)(c)	Yes	No	Yes	Yes	N/A - LOS	N/A - NLOS	Yes
40	10	b(6), b(7)(c)	Yes	No	Yes	Yes	N/A - LOS	Yes	Yes

AMERICAN OVERSIGHT

	J	K
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18	atients or those on multiple	
19		
20		
21		
22		
23		
24		
25		
26	8	
27	7	
28	88%	
29		
30	**cDM-8**	
31	N/A - LOS	
32	Yes	
33	Yes	
34	Yes	
35	No	
36	Yes	
37	N/A - LOS	
38	Yes	
39	Yes	
40	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HIV**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		7						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
6	**Sample:**	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
7		National Institutes of Health. Aids Info.		https://aidsinfo.nih.gov/guidelines			http://nccc.ucsf.edu		
8	**Guidelines:**	University of California, San Francisco. HIV Clinical Consultation Center.							
9		ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
10	**Remarks:**			Type Text Here					
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
12									
13				**Facility (f)**					
14	**~~fHIV-1:~~**	What clinical practice guideline does the facility							
15		use to manage HIV?				~~BOP Clinical Practice Guidelines~~			
16									
17				**Clinical (c)**					
18	**cHIV-1**	How was HIV status identified? By laboratory, prior medical records or patient report?							
19	**cHIV-2**	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
20	**cHIV-3**	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
21	**cHIV-4**	Was antiretroviral treatment considered and documented?							
22	**cHIV-5**	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
23	**cHIV-6**	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
24									
25	**Total Applicable:**			7	7	7	7	7	
26	**Total Met:**			7	7	7	7	7	
27	**% Compliance:**	100%		100%	100%	100%	100%	100%	
28									
29	**Patient(s)**	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
30	1	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
31	2	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
32	3	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
33	4	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
34	5	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
35	6	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
36	7	b(6), b(7)(c)	Medical Record	Yes	Yes	Yes	Yes	Yes	
37	8		Select	Select	Select	Select	Select	Select	
38	9		Select	Select	Select	Select	Select	Select	
39	10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HYPERTENSION**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with hypertension chosen at random, if available.							
7	**~~Guidelines:~~**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9									
10	**Remarks:**	Per the Regional Medical Director, the local policy for initial chronic care clinic is 30 days after intake process.							
11									
12	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
13									
14				**Facility (f)**					
15	**fHTN-1a:**	Does the facility follow a clinical practice guideline to manage hypertension?						Y	
16	**~~fHTN-1b:~~**	~~If yes, what is the guideline?~~			~~BOP Clinical Practice Guidelines~~				
17									
18									
19				**Clinical (c)**					
20	**cHTN-1**	Was a blood pressure reading noted at intake?							
21	**cHTN-2**	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
22	**cHTN-3**	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cHTN-4**	Was a chronic disease guideline, including baseline laboratory testing, followed?							
24									
25	**Total Applicable:**		10	10	10	10			
26	**Total Met:**		10	0	10	10			
27	**% Compliance:**	75%	100%	0%	100%	100%			
28									
29	**Patient(s)**	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
30	1	b(6), b(7)(c)	Y	No	Yes	Yes			
31	2	b(6), b(7)(c)	Y	No	Yes	Yes			
32	3	b(6), b(7)(c)	Y	No	Yes	Yes			
33	4	b(6), b(7)(c)	Y	No	Yes	Yes			
34	5	b(6), b(7)(c)	Y	No	Yes	Yes			
35	6	b(6), b(7)(c)	Y	No	Yes	Yes			
36	7	b(6), b(7)(c)	Y	No	Yes	Yes			
37	8	b(6), b(7)(c)	Y	No	Yes	Yes			
38	9	b(6), b(7)(c)	Y	No	Yes	Yes			
39	10	b(6), b(7)(c)	Y	No	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**SEIZURE DISORDER**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To prevent deterioration in function and cost of unnecessary care.						
5	**Source:**	Chronic disease registry or MARs.						
6	**Sample:**	10 patients with seizure disorder chosen at random, if available.						
7	**Guidelines:**							
8								
9	**Remarks:**	Per the Regional Medical Director, the local policy for initial chronic care clinic is 30 days after intake process.						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13				**Facility (f)**				
14	**fSZ-1:**	What clinical practice guideline does the facility			BOP Clinical Practice Guidelines			
15		use to manage seizures?						
16								
17				**Clinical (c)**				
18	**cSZ-1**	Was an appropriate neurological history completed at the initial physical examination?						
19	**cSZ-2**	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.						
20	**cSZ-3**	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?						
21	**cSZ-4**	Was a treatment plan established?						
22	**cSZ-5**	Are there orders for a bottom bunk?						
23								
24	**Total Applicable:**		10	9	7	7	10	
25	**Total Met:**		10	3	7	7	10	
26	**% Compliance:**	87%	100%	33%	100%	100%	100%	
27								
28	**Patient(s)**	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**	
29	1	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	
30	2	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	
31	3	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	
32	4	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	
33	5	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	
34	6	b(6), b(7)(c)	Yes	Yes	N/A - LOS	N/A - LOS	Yes	
35	7	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
36	8	b(6), b(7)(c)	Yes	N/A - LOS	N/A - LOS	N/A - LOS	Yes	
37	9	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
38	10	b(6), b(7)(c)	Yes	No	N/A - LOS	N/A - LOS	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1			**CONTINUITY OF MEDICATIONS**						
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess timeliness of medication, as ordered.							
5	**Source:**	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).							
6	**Sample:**	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.							
7	**Guidelines:**								
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
12									
13				**Clinical (c)**					
14	**cCM-1**	Period of time from completion of intake screening to the ordering of medications less than 24 hours?							
15	**cCM-2**	Period of time from order to first dose less than 24 hours?							
16									
17	**Total Applicable:**		10	10					
18	**Total Met:**		10	10					
19	**% Compliance:**	100%	100%	100%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cCM-1**	**cCM-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	Yes					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	Yes					
26	5	b(6), b(7)(c)	Yes	Yes					
27	6	b(6), b(7)(c)	Yes	Yes					
28	7	b(6), b(7)(c)	Yes	Yes					
29	8	b(6), b(7)(c)	Yes	Yes					
30	9	b(6), b(7)(c)	Yes	Yes					
31	10	b(6), b(7)(c)	Yes	Yes					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**DENTAL CARE**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess compliance with detention standards and continuity of care.							
5	**Source:**	Dental sick call list or dental referral log.							
6	**Sample:**	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)©			**Date Reviewed:**		5/9/2019		
12									
13				**Clinical (c)**					
14	**cDC-1**	Was patient screened for symptoms during the intake process?							
15	**cDC-2**	Was patient evaluated by a qualified health professional within 48 hours of request?							
16	**cDC-3**	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
17	**cDC-4**	Was the patient scheduled for follow-up treatment as recommended?							
18									
19	**Total Applicable:**		10	10	10	10			
20	**Total Met:**		10	10	10	10			
21	**% Compliance:**	100%	100%	100%	100%	100%			
22									
23	**Patient(s)**	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
24	1	b(6), b(7)(c)	Y	Yes	Yes	Yes			
25	2	b(6), b(7)(c)	Y	Yes	Yes	Yes			
26	3	b(6), b(7)(c)	Y	Yes	Yes	Yes			
27	4	b(6), b(7)(c)	Y	Yes	Yes	Yes			
28	5	b(6), b(7)(c)	Y	Yes	Yes	Yes			
29	6	b(6), b(7)(c)	Y	Yes	Yes	Yes			
30	7	b(6), b(7)(c)	Y	Yes	Yes	Yes			
31	8	b(6), b(7)(c)	Y	Yes	Yes	Yes			
32	9	b(6), b(7)(c)	Y	Yes	Yes	Yes			
33	10	b(6), b(7)(c)	Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** (please select 0 if no files/patients reviewed)		10					
3				10				
4	**Purpose:**	To assess timeliness of off-site diagnostic services and specialty care.						
5	**Source:**	Referrals log, medical records or MedPars.						
6	**Sample:**	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
7	**Guidelines:**	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13			**Clinical (c)**					
14	**cDSA-1**	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
15	**cDSA-2**	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., “return in 90 days”?						
16	**cDSA-3**	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
17	**cDSA-4**	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
18								
19	**Total Applicable:**			10	10	10	10	
20	**Total Met:**			10	10	10	10	
21	**% Compliance:**	100%		100%	100%	100%	100%	
22								
23	**Patient(s)**	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
24	1	b(6), b(7)(c)	Orthopedics	Yes	Yes	Yes	Yes	
25	2	b(6), b(7)(c)	Other	Yes	Yes	Yes	Yes	
26	3	b(6), b(7)(c)	Orthopedics	Yes	Yes	Yes	Yes	
27	4	b(6), b(7)(c)	Hematology	Yes	Yes	Yes	Yes	
28	5	b(6), b(7)(c)	Neurology	Yes	Yes	Yes	Yes	
29	6	b(6), b(7)(c)	Opthalmology	Yes	Yes	Yes	Yes	
30	7	b(6), b(7)(c)	Other	Yes	Yes	Yes	Yes	
31	8	b(6), b(7)(c)	Cardiology	Yes	Yes	Yes	Yes	
32	9	b(6), b(7)(c)	Other	Yes	Yes	Yes	Yes	
33	10	b(6), b(7)(c)	Other	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbou						
5	**Source:**	Emergency Department (ED) logs.						
6	**Sample:**	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, sk tissue infections, DKA, abdominal pain, or chest pain.						
7	**Guidelines:**	NCCHC 2014 J-E-12.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		5/9/20
12								
13			**Clinical (c)**					
14	**cEED-1**	Is there an outbound progress note?						
15	**cEED-2**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the repor						
16	**cEED-3**	Is there discharge documentation from the hospital or ED in the chart?						
17	**cEED-4**	Is there an inbound assessment?						
18	**cEED-5**	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?						
19								
20	**Total Applicable:**			10	10	10	10	10
21	**Total Met:**			10	10	10	10	10
22	**% Compliance:**	100%		100%	100%	100%	100%	100%
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
25	1	b(6), b(7)(c)	chest pain	Yes	No	Yes	Yes	Yes
26	2	b(6), b(7)(c)	abnormal EKG	Yes	No	Yes	Yes	Yes
27	3	b(6), b(7)(c)	abdominal pain, left lower extremity pain	Yes	No	Yes	Yes	Yes
28	4	b(6), b(7)(c)	rule out deep vain thrombosis,left lower leg	Yes	No	Yes	Yes	Yes
29	5	b(6), b(7)(c)	abdominal pain	Yes	No	Yes	Yes	Yes
30	6	b(6), b(7)(c)	chest pain	Yes	No	Yes	Yes	Yes
31	7	b(6), b(7)(c)	seizure	Yes	No	Yes	Yes	Yes
32	8	b(6), b(7)(c)	abdominal pain	Yes	No	Yes	Yes	Yes
33	9	b(6), b(7)(c)	seizure	Yes	No	Yes	Yes	Yes
34	10	b(6), b(7)(c)	abnormal chest xray	Yes	No	Yes	Yes	Yes

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**COMPLAINTS AND GRIEVANCES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		19					
3				19				
4	**Purpose:**	To assess use of medical grievance data as part of the quality management program.						
5	**Source:**	Facility grievance logs.						
6	**Sample:**	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
7	**Guidelines:**	NCCHC 2014 J-A-06, J-A-11.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**	5/9/2019	
12								
13				**Facility (f)**				
14	**fCG-1:**	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care?						N
15		If yes, please address in the remarks section whether and how the facility uses this information to implement change.						
16	**fCG-2:**	How many medical grievances were submitted over the past 3 months?				13		
17	**fCG-3:**	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?				12		
18								
19				**Clinical (c)**				
20	**cCG-1**	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
21	**cCG-2**	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
22								
23	**Totals:**	13	1	1	4	2	2	9
24								
25	**Patient(s)**	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
26	1	b(6), b(7)(c)	1	0	1	0	0	0
27	2	b(6), b(7)(c)	0	1	0	0	0	0
28	3	b(6), b(7)(c)	0	0	1	0	0	0
29	4	b(6), b(7)(c)	0	0	1	0	0	0
30	5	b(6), b(7)(c)	0	0	1	0	0	0
31	6	b(6), b(7)(c)	0	0	0	1	1	1
32	7	b(6), b(7)(c)	0	0	0	1	0	0
33	8	b(6), b(7)(c)	0	0	0	0	1	0
34	9	b(6), b(7)(c)	0	0	0	0	0	1
35	10	b(6), b(7)(c)	0	0	0	0	0	3
36	11	b(6), b(7)(c)	0	0	0	0	0	1
37	12	b(6), b(7)(c)	0	0	0	0	0	2

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	A	B	C	D	E	F	G	H
38	13	b(6), b(7)(c)	0	0	0	0	0	1
39	14		Select	Select	Select	Select	Select	Select
40	15		Select	Select	Select	Select	Select	Select
41	16		Select	Select	Select	Select	Select	Select
42	17		Select	Select	Select	Select	Select	Select
43	18		Select	Select	Select	Select	Select	Select
44	19		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**HEALTH ASSESSMENT**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		20					
3				20				
4	**Purpose:**	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.						
5	**Source:**	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.						
6	**Sample:**	20 medical records chosen at random.						
7	**Guidelines:**	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13			**Clinical (c)**					
14	**cHA-1**	Initial screen complete within 12 hours of booking?						
15	**cHA-2**	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?						
16	**cHA-3**	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?						
17	**cHA-4**	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.						
18	**cHA-5**	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.						
19				**0**				
20	**Total Applicable:**		20	20	20	20	20	
21	**Total Met:**		20	20	20	20	18	
22	**% Compliance:**	98%	100%	100%	100%	100%	90%	
23								
24	**Patient(s)**	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**	
25	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
26	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes	No	
27	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes	No	
28	4	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
29	5	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
30	6	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
31	7	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
32	8	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
33	9	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
34	10	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
35	11	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
36	12	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
37	13	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
38	14	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
39	15	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	

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	A	B	C	D	E	F	G	H
40	16	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
41	17	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
42	18	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
43	19	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
44	20	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**LABORATORY TESTING**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To assess timeliness, continuity, and coordination of care.						
5	**Source:**	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
6	**Sample:**	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
7	**Guidelines:**							
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13			**Clinical (c)**					
14	**cLT-1**	Was blood drawn or test done within 1 business day of ordered date?						
15	**cLT-2**	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
16	**cLT-3**	Was there clinical acknowledgment?						
17	**cLT-4**	Was there an appropriate clinical response?						
18	**cLT-5**	Was patient advised of laboratory results?						
19								
20	**Total Applicable:**		10	10	9	10	10	
21	**Total Met:**		10	10	9	10	10	
22	**% Compliance:**	100%	100%	100%	100%	100%	100%	
23								
24	**Patient(s)**	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
25	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
26	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
27	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
28	4	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
29	5	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
30	6	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
31	7	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
32	8	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
33	9	b(6), b(7)(c)	Yes	Yes	Select	Yes	Yes	
34	10	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**MEDICATION ADMINISTRATION RECORDS**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		Select						
3				10					
4	**Purpose:**	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
5	**Source:**	MARS.							
6	**Sample:**	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
7	**Guidelines:**								
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
12									
13				**Facility (f)**					
14	**fMAR-1:**	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?						Y	
15	**fMAR-2:**	Based on review of current month MARs or previous month's MARs, if available, what						0	
16		percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?							
17	**fMAR-3:**	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?						0	
18	**fMAR-4:**	Estimate the percentage of patients on self-administered medication ordered by a provider.						60	
19	**fMAR-5:**	OTCs provided by medical, commissary or both?						Both	
20									
21				**Clinical (c)**					
22	**cMAR-1**	What is the number of refusals and no shows during the previous month for each patient?							
23	**cMAR-2**	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
24	**cMAR-3**	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
25									
26	**Total Applicable:**			0	0				
27	**Total Met:**			0	0				
28	**% Compliance:**								
29									
30	**Patient(s)**	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
31	1		Select	Select	Select				
32	2		Select	Select	Select				
33	3		Select	Select	Select				
34	4		Select	Select	Select				
35	5		Select	Select	Select				
36	6		Select	Select	Select				
37	7		Select	Select	Select				
38	8		Select	Select	Select				
39	9		Select	Select	Select				

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	A	B	C	D	E	F	G	H	I
40	10		Select	Select	Select				

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**MEDICAL RECORD-KEEPING PRACTICES**			
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10				
3							
4	**Purpose:**	To assess completeness of the medical record and appropriateness of medical record practices.					
5	**Source:**	Medical Records, Chronic Care Log, and MARs.					
6	**Sample:**	10 records of detainees with chronic disease, if available.					
7	**Instructions:**	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For exa progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."					
8	**Guidelines:**	NCCHC 2014 J-H-01, J-H-03.					
9							
10	**Remarks:**				Type Text Here		
11							
12	**Reviewer:**		b(6), b(7)(c)		**Date Reviewed:**	5/9/2019	
13							
14				**Facility (f)**			
15	**fMR-1:**	Type of Medical Records?		Electronic			
16	**~~fMR-2:~~**	~~Name of Electronic Health Record?~~				~~ALLSCRIPTS EMR~~	
17							
18							
19	**Total Applicable:**		10	10	10	10	10
20	**Total Met:**		10	10	10	10	10
21	**% Compliance:**	100%	100%	100%	100%	100%	100%
22							
23	**Patient(s)**	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments; known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**
24	1	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
25	2	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
26	3	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
27	4	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
28	5	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
29	6	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
30	7	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
31	8	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
32	9	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
33	10	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

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18	
19	10
20	10
21	100%
22	
23	**MARs:** Placed in record within 2 weeks of previous month
24	Compliant
25	Compliant
26	Compliant
27	Compliant
28	Compliant
29	Compliant
30	Compliant
31	Compliant
32	Compliant
33	Compliant

AMERICAN OVERSIGHT

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18								
19	10	10	10	0	5	5	0	0
20	10	10	10	0	5	5	0	0
21	100%	100%	100%		100%	100%		
22								
23	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**
24	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A
25	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A
26	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A
27	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A
28	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A	N/A
29	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
30	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
31	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
32	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
33	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A

AMERICAN OVERSIGHT

	Q	R	S	T	U	V	W
1							
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18							
19	10	10	10	10	10	10	10
20	10	10	10	10	10	10	10
21	100%	100%	100%	100%	100%	100%	100%
22							
23	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
24	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
25	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
26	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
27	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
28	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
29	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
30	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
31	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
32	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
33	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1			**MENTAL HEALTH SCREEN**						
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
5	**Source:**	Intake screens of detainees, mental health referral logs, mental health caseload.							
6	**Sample:**	10 randomly selected intake screens with positive mental health screens, if available.							
7	**Guidelines:**								
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
12									
13			**Clinical (c)**						
14	**cMHS-1**	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
15									
16	**Total Applicable:**		10						
17	**Total Met:**		10						
18	**% Compliance:**	100%	100%						
19									
20	**Patient(s)**	**A# (numbers only)**	**cMHS-1**						
21	1	b(6), b(7)(c)	Yes						
22	2	b(6), b(7)(c)	Yes						
23	3	b(6), b(7)(c)	Yes						
24	4	b(6), b(7)(c)	Yes						
25	5	b(6), b(7)(c)	Yes						
26	6	b(6), b(7)(c)	Yes						
27	7	b(6), b(7)(c)	Yes						
28	8	b(6), b(7)(c)	Yes						
29	9	b(6), b(7)(c)	Yes						
30	10	b(6), b(7)(c)	Yes						

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**MENTAL HEALTH TREATMENT PLANNING**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).							
5	**Source:**	Patients on mental health caseload, including all patients on psychotropic medication.							
6	**Sample:**	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.							
7	**Guidelines:**	NCCHC 2014 J-G-04 (Item 2)							
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019		
12									
13				**Clinical (c)**					
14	**cMHT-1**	Is a clinical assessment, treatment, and follow-up plan documented?							
15	**cMHT-2**	Are treatment plans updated at a minimum of every 90 days?							
16									
17	**Total Applicable:**		10	10					
18	**Total Met:**		10	10					
19	**% Compliance:**	100%	100%	100%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cMHT-1**	**cMHT-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	Yes					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	Yes					
26	5	b(6), b(7)(c)	Yes	Yes					
27	6	b(6), b(7)(c)	Yes	Yes					
28	7	b(6), b(7)(c)	Yes	Yes					
29	8	b(6), b(7)(c)	Yes	Yes					
30	9	b(6), b(7)(c)	Yes	Yes					
31	10	b(6), b(7)(c)	Yes	Yes					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**PREGNANT WOMEN**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To determine compliance with detention standards and continuity and coordination of care.						
5	**Source:**	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
6	**Sample:**	10 pregnant detainees, if available.						
7	**Guidelines:**	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
8								
9	**Remarks:**			The Facility only house male detainee.				
10								
11	**Reviewer:**	b(6), b(7)(c)				**Date Reviewed:**	5/9/2019	
12								
13				**Facility (f)**				
14	**fPG-1:**	Does the facility perform a pregnancy test on females aged 10 to 56 during				N/A		
15		intake screening?						
16								
17				**Clinical (c)**				
18	**cPG-1**	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
19	**cPG-2**	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
20	**cPG-3**	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
21	**cPG-4**	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
22	**cPG-5**	Were prenatal vitamins prescribed?						
23								
24	**Total Applicable:**		0	0	0	0	0	
25	**Total Met:**		0	0	0	0	0	
26	**% Compliance:**							
27								
28	**Patient(s)**	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
29	1		Select	Select	Select	Select	Select	
30	2		Select	Select	Select	Select	Select	
31	3		Select	Select	Select	Select	Select	
32	4		Select	Select	Select	Select	Select	
33	5		Select	Select	Select	Select	Select	
34	6		Select	Select	Select	Select	Select	
35	7		Select	Select	Select	Select	Select	
36	8		Select	Select	Select	Select	Select	
37	9		Select	Select	Select	Select	Select	
38	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**SUICIDE SCREENING**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.						
5	**Source:**	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
6	**Sample:**	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
7	**Guidelines:**	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13				**Facility (f)**				
14	**fSS-1:**	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?					17	
15	**fSS-2:**	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?					Y	
16	**fSS-3:**	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?					Y	
17								
18				**Clinical (c)**				
19	**cSS-1**	What type of monitoring was practiced while the patient was on suicide watch?						
20	**cSS-2**	Were checks documented consistently?						
21	**cSS-3**	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?						
22	**cSS-4**	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?						
23	**cSS-5**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.						
24								
25	**Total Applicable:**			10	10	10	10	
26	**Total Met:**			10	10	10	10	
27	**% Compliance:**	100%		100%	100%	100%	100%	
28								
29	**Patient(s)**	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**	
30	1	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
31	2	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
32	3	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
33	4	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
34	5	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
35	6	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
36	7	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
37	8	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	
38	9	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
39	10	b(6), b(7)(c)	At least q 15 min	Yes	Yes	Yes	No	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**TREATMENT OF DISABILITY**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		7					
3				10				
4	**Purpose:**	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment. See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf						
5	**Source:**	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
6	**Sample:**	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
7	**Guidelines:**	NCCHC J-G-02.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		5/9/2019	
12								
13				**Facility (f)**				
14	**fTD-1:**	Does the facility maintain a current list of all patients with disabilities on site?					Y	
15								
16				**Clinical (c)**				
17	**cTD-1**	Is the disability prominently noted in the file, along with any needed accommodations?						
18	**cTD-2**	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
19	**cTD-3**	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
20	**cTD-4**	Was ADL assistance provided, if applicable?						
21								
22	**Total Applicable:**		7	7	7	7		
23	**Total Met:**		7	7	7	1		
24	**% Compliance:**	79%	100%	100%	100%	14%		
25								
26	**Patient(s)**	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
27	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes		
28	2	b(6), b(7)(c)	Yes	Yes	Yes	No		
29	3	b(6), b(7)(c)	Yes	Yes	Yes	No		
30	4	b(6), b(7)(c)	Yes	Yes	Yes	No		
31	5	b(6), b(7)(c)	Yes	Yes	Yes	No		
32	6	b(6), b(7)(c)	Yes	Yes	Yes	No		
33	7	b(6), b(7)(c)	Yes	Yes	Yes	No		
34	8		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
35	9		Select	Select	Select	Select		
36	10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**URGENT CARE (SICK CALL)**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** (please select 0 if no files/patients reviewed)		10	Add Sample Rows		Reset Sample Rows		
3				10				
4	**Purpose:**	To assess for timely and appropriate nursing care for acute conditions.						
5	**Source:**	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
6	**Sample:**	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious con include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**		Type Text Here			**Date Reviewed:**		Select
12								
13				**Clinical (c)**				
14	**cUC-1**	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
15	**cUC-2**	Was care delivered within the scope of the nurse's license?						
16	**cUC-3**	Were vital signs documented during the nurse's assessment?						
17	**cUC-4**	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
18	**cUC-5**	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
19								
20	**Total Applicable:**			10	10	10	4	4
21	**Total Met:**			10	10	10	4	4
22	**% Compliance:**	100%		100%	100%	100%	100%	100%
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
25	1	b(6), b(7)(c)	eye problem	Yes	Yes	Yes	Yes	Yes
26	2	b(6), b(7)(c)	cough/colds	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
27	3	b(6), b(7)(c)	headache	Yes	Yes	Yes	Yes	Yes
28	4	b(6), b(7)(c)	cough/colds	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
29	5	b(6), b(7)(c)	right knee pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
30	6	b(6), b(7)(c)	constipation	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
31	7	b(6), b(7)(c)	blood in urine	Yes	Yes	Yes	Yes	Yes
32	8	b(6), b(7)(c)	sports related injury to finger	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
33	9	b(6), b(7)(c)	cough	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
34	10	b(6), b(7)(c)	body malaise	Yes	Yes	Yes	Yes	Yes

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1											
2			**Dates**	**States**							
3	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select
4	Yes	Yes	12/1/2017	AL	Recent Lab	Y	Cardiology	Medical	Paper	Compliant	Constant (1:1)
5	No	No	12/2/2017	AK	Patient Interview	N	Endocrinology	Commissary	Electronic	Partial Compliance	Constant (camera)
6	N/A	N/A - LOS	12/3/2017	AZ	Medical Record		Gastroenterology	Both	Both	Non-Compliant	At least q 15 min
7		N/A - NLOS	12/4/2017	AR			General Surgery			N/A	Less often
8			12/5/2017	CA			Hematology				
9			12/6/2017	CO			Infectious Disease				
10			12/7/2017	CT			Neurology				
11			12/8/2017	DE			OB/Gyn				
12			12/9/2017	FL			Oncology				
13			12/10/2017	GA			Opthalmology				
14			12/11/2017	HI			Orthopedics				
15			12/12/2017	ID			Psychiatry				
16			12/13/2017	IL			Pulmonology				
17			12/14/2017	IN			Rheumatology				
18			12/15/2017	IA			Other				
19			12/16/2017	KS							
20			12/17/2017	KY							
21			12/18/2017	LA							
22			12/19/2017	ME							
23			12/20/2017	MD							
24			12/21/2017	MA							
25			12/22/2017	MI							
26			12/23/2017	MN							
27			12/24/2017	MS							
28			12/25/2017	MO							
29			12/26/2017	MT							
30			12/27/2017	NE							
31			12/28/2017	NV							
32			12/29/2017	NH							
33			12/30/2017	NJ							
34			12/31/2017	NM							
35			1/1/2018	NY							
36			1/2/2018	NC							
37			1/3/2018	ND							
38			1/4/2018	OH							
39			1/5/2018	OK							
40			1/6/2018	OR							
41			1/7/2018	PA							
42			1/8/2018	RI							
43			1/9/2018	SC							
44			1/10/2018	SD							
45			1/11/2018	TN							
46			1/12/2018	TX							

AMERICAN OVERSIGHT

	L	M	N
1			
2		**Organization**	**AOR**
3	Select	Select	Select
4	0	IHSC	ATL
5	1	Other	BAL
6	2		BOS
7	3		BUF
8	4		CHI
9	5		DAL
10	6		DEN
11	7		DET
12	8		ELP
13	9		HOU
14	10		LOS
15	11		MIA
16	12		NEW
17	13		NOL
18	14		NYC
19	15		PHI
20	16		PHO
21	17		SEA
22	18		SFR
23	19		SLC
24	20		SNA
25	21		SND
26	22		SPM
27	23		WAS
28	24		COW
29	25		
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46	42		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
47			1/13/2018	UT							
48			1/14/2018	VT							
49			1/15/2018	VA							
50			1/16/2018	WA							
51			1/17/2018	WV							
52			1/18/2018	WI							
53			1/19/2018	WY							
54			1/20/2018								
55			1/21/2018								
56			1/22/2018								
57			1/23/2018								
58			1/24/2018								
59			1/25/2018								
60			1/26/2018								
61			1/27/2018								
62			1/28/2018								
63			1/29/2018								
64			1/30/2018								
65			1/31/2018								
66			2/1/2018								
67			2/2/2018								
68			2/3/2018								
69			2/4/2018								
70			2/5/2018								
71			2/6/2018								
72			2/7/2018								
73			2/8/2018								
74			2/9/2018								
75			2/10/2018								
76			2/11/2018								
77			2/12/2018								
78			2/13/2018								
79			2/14/2018								
80			2/15/2018								
81			2/16/2018								
82			2/17/2018								
83			2/18/2018								
84			2/19/2018								
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88			2/23/2018								
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91			2/26/2018								
92			2/27/2018								

AMERICAN OVERSIGHT

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47	43		
48	44		
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92	88		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
93			2/28/2018								
94			3/1/2018								
95			3/2/2018								
96			3/3/2018								
97			3/4/2018								
98			3/5/2018								
99			3/6/2018								
100			3/7/2018								
101			3/8/2018								
102			3/9/2018								
103			3/10/2018								
104			3/11/2018								
105			3/12/2018								
106			3/13/2018								
107			3/14/2018								
108			3/15/2018								
109			3/16/2018								
110			3/17/2018								
111			3/18/2018								
112			3/19/2018								
113			3/20/2018								
114			3/21/2018								
115			3/22/2018								
116			3/23/2018								
117			3/24/2018								
118			3/25/2018								
119			3/26/2018								
120			3/27/2018								
121			3/28/2018								
122			3/29/2018								
123			3/30/2018								
124			3/31/2018								
125			4/1/2018								
126			4/2/2018								
127			4/3/2018								
128			4/4/2018								
129			4/5/2018								
130			4/6/2018								
131			4/7/2018								
132			4/8/2018								
133			4/9/2018								
134			4/10/2018								
135			4/11/2018								
136			4/12/2018								
137			4/13/2018								
138			4/14/2018								

AMERICAN OVERSIGHT

	L	M	N
93	89		
94	90		
95	91		
96	92		
97	93		
98	94		
99	95		
100	96		
101	97		
102	98		
103	99		
104	100		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
139			4/15/2018								
140			4/16/2018								
141			4/17/2018								
142			4/18/2018								
143			4/19/2018								
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154			4/30/2018								
155			5/1/2018								
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182			5/28/2018								
183			5/29/2018								
184			5/30/2018								

AMERICAN OVERSIGHT

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139	135		
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181	177		
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183	179		
184	180		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
185			5/31/2018								
186			6/1/2018								
187			6/2/2018								
188			6/3/2018								
189			6/4/2018								
190			6/5/2018								
191			6/6/2018								
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212			6/27/2018								
213			6/28/2018								
214			6/29/2018								
215			6/30/2018								
216			7/1/2018								
217			7/2/2018								
218			7/3/2018								
219			7/4/2018								
220			7/5/2018								
221			7/6/2018								
222			7/7/2018								
223			7/8/2018								
224			7/9/2018								
225			7/10/2018								
226			7/11/2018								
227			7/12/2018								
228			7/13/2018								
229			7/14/2018								
230			7/15/2018								

AMERICAN OVERSIGHT

	L	M	N
185	181		
186	182		
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224	220		
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227	223		
228	224		
229	225		
230	226		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
231			7/16/2018								
232			7/17/2018								
233			7/18/2018								
234			7/19/2018								
235			7/20/2018								
236			7/21/2018								
237			7/22/2018								
238			7/23/2018								
239			7/24/2018								
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242			7/27/2018								
243			7/28/2018								
244			7/29/2018								
245			7/30/2018								
246			7/31/2018								
247			8/1/2018								
248			8/2/2018								
249			8/3/2018								
250			8/4/2018								
251			8/5/2018								
252			8/6/2018								
253			8/7/2018								
254			8/8/2018								
255			8/9/2018								
256			8/10/2018								
257			8/11/2018								
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261			8/15/2018								
262			8/16/2018								
263			8/17/2018								
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265			8/19/2018								
266			8/20/2018								
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268			8/22/2018								
269			8/23/2018								
270			8/24/2018								
271			8/25/2018								
272			8/26/2018								
273			8/27/2018								
274			8/28/2018								
275			8/29/2018								
276			8/30/2018								

AMERICAN OVERSIGHT

	L	M	N
231	227		
232	228		
233	229		
234	230		
235	231		
236	232		
237	233		
238	234		
239	235		
240	236		
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256	252		
257	253		
258	254		
259	255		
260	256		
261	257		
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268	264		
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270	266		
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272	268		
273	269		
274	270		
275	271		
276	272		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
277			8/31/2018								
278			9/1/2018								
279			9/2/2018								
280			9/3/2018								
281			9/4/2018								
282			9/5/2018								
283			9/6/2018								
284			9/7/2018								
285			9/8/2018								
286			9/9/2018								
287			9/10/2018								
288			9/11/2018								
289			9/12/2018								
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291			9/14/2018								
292			9/15/2018								
293			9/16/2018								
294			9/17/2018								
295			9/18/2018								
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297			9/20/2018								
298			9/21/2018								
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306			9/29/2018								
307			9/30/2018								
308			10/1/2018								
309			10/2/2018								
310			10/3/2018								
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313			10/6/2018								
314			10/7/2018								
315			10/8/2018								
316			10/9/2018								
317			10/10/2018								
318			10/11/2018								
319			10/12/2018								
320			10/13/2018								
321			10/14/2018								
322			10/15/2018								

AMERICAN OVERSIGHT

	L	M	N
277	273		
278	274		
279	275		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
323			10/16/2018								
324			10/17/2018								
325			10/18/2018								
326			10/19/2018								
327			10/20/2018								
328			10/21/2018								
329			10/22/2018								
330			10/23/2018								
331			10/24/2018								
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334			10/27/2018								
335			10/28/2018								
336			10/29/2018								
337			10/30/2018								
338			10/31/2018								
339			11/1/2018								
340			11/2/2018								
341			11/3/2018								
342			11/4/2018								
343			11/5/2018								
344			11/6/2018								
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349			11/11/2018								
350			11/12/2018								
351			11/13/2018								
352			11/14/2018								
353			11/15/2018								
354			11/16/2018								
355			11/17/2018								
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359			11/21/2018								
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363			11/25/2018								
364			11/26/2018								
365			11/27/2018								
366			11/28/2018								
367			11/29/2018								
368			11/30/2018								

AMERICAN OVERSIGHT

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323	319		
324	320		
325	321		
326	322		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
369			12/1/2018								
370			12/2/2018								
371			12/3/2018								
372			12/4/2018								
373			12/5/2018								
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384			12/16/2018								
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389			12/21/2018								
390			12/22/2018								
391			12/23/2018								
392			12/24/2018								
393			12/25/2018								
394			12/26/2018								
395			12/27/2018								
396			12/28/2018								
397			12/29/2018								
398			12/30/2018								
399			12/31/2018								
400			1/1/2019								
401			1/2/2019								
402			1/3/2019								
403			1/4/2019								
404			1/5/2019								
405			1/6/2019								
406			1/7/2019								
407			1/8/2019								
408			1/9/2019								
409			1/10/2019								
410			1/11/2019								
411			1/12/2019								
412			1/13/2019								
413			1/14/2019								
414			1/15/2019								

AMERICAN OVERSIGHT

	L	M	N
369	365		
370	366		
371	367		
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414	410		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
415			1/16/2019								
416			1/17/2019								
417			1/18/2019								
418			1/19/2019								
419			1/20/2019								
420			1/21/2019								
421			1/22/2019								
422			1/23/2019								
423			1/24/2019								
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425			1/26/2019								
426			1/27/2019								
427			1/28/2019								
428			1/29/2019								
429			1/30/2019								
430			1/31/2019								
431			2/1/2019								
432			2/2/2019								
433			2/3/2019								
434			2/4/2019								
435			2/5/2019								
436			2/6/2019								
437			2/7/2019								
438			2/8/2019								
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440			2/10/2019								
441			2/11/2019								
442			2/12/2019								
443			2/13/2019								
444			2/14/2019								
445			2/15/2019								
446			2/16/2019								
447			2/17/2019								
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450			2/20/2019								
451			2/21/2019								
452			2/22/2019								
453			2/23/2019								
454			2/24/2019								
455			2/25/2019								
456			2/26/2019								
457			2/27/2019								
458			2/28/2019								
459			3/1/2019								
460			3/2/2019								

AMERICAN OVERSIGHT

	L	M	N
415	411		
416	412		
417	413		
418	414		
419	415		
420	416		
421	417		
422	418		
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459	455		
460	456		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
461			3/3/2019								
462			3/4/2019								
463			3/5/2019								
464			3/6/2019								
465			3/7/2019								
466			3/8/2019								
467			3/9/2019								
468			3/10/2019								
469			3/11/2019								
470			3/12/2019								
471			3/13/2019								
472			3/14/2019								
473			3/15/2019								
474			3/16/2019								
475			3/17/2019								
476			3/18/2019								
477			3/19/2019								
478			3/20/2019								
479			3/21/2019								
480			3/22/2019								
481			3/23/2019								
482			3/24/2019								
483			3/25/2019								
484			3/26/2019								
485			3/27/2019								
486			3/28/2019								
487			3/29/2019								
488			3/30/2019								
489			3/31/2019								
490			4/1/2019								
491			4/2/2019								
492			4/3/2019								
493			4/4/2019								
494			4/5/2019								
495			4/6/2019								
496			4/7/2019								
497			4/8/2019								
498			4/9/2019								
499			4/10/2019								
500			4/11/2019								
501			4/12/2019								
502			4/13/2019								
503			4/14/2019								
504			4/15/2019								
505			4/16/2019								
506			4/17/2019								

AMERICAN OVERSIGHT

	L	M	N
461	457		
462	458		
463	459		
464	460		
465	461		
466	462		
467	463		
468	464		
469	465		
470	466		
471	467		
472	468		
473	469		
474	470		
475	471		
476	472		
477	473		
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503	499		
504	500		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
507			4/18/2019								
508			4/19/2019								
509			4/20/2019								
510			4/21/2019								
511			4/22/2019								
512			4/23/2019								
513			4/24/2019								
514			4/25/2019								
515			4/26/2019								
516			4/27/2019								
517			4/28/2019								
518			4/29/2019								
519			4/30/2019								
520			5/1/2019								
521			5/2/2019								
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523			5/4/2019								
524			5/5/2019								
525			5/6/2019								
526			5/7/2019								
527			5/8/2019								
528			5/9/2019								
529			5/10/2019								
530			5/11/2019								
531			5/12/2019								
532			5/13/2019								
533			5/14/2019								
534			5/15/2019								
535			5/16/2019								
536			5/17/2019								
537			5/18/2019								
538			5/19/2019								
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540			5/21/2019								
541			5/22/2019								
542			5/23/2019								
543			5/24/2019								
544			5/25/2019								
545			5/26/2019								
546			5/27/2019								
547			5/28/2019								
548			5/29/2019								
549			5/30/2019								
550			5/31/2019								
551			6/1/2019								
552			6/2/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
553			6/3/2019								
554			6/4/2019								
555			6/5/2019								
556			6/6/2019								
557			6/7/2019								
558			6/8/2019								
559			6/9/2019								
560			6/10/2019								
561			6/11/2019								
562			6/12/2019								
563			6/13/2019								
564			6/14/2019								
565			6/15/2019								
566			6/16/2019								
567			6/17/2019								
568			6/18/2019								
569			6/19/2019								
570			6/20/2019								
571			6/21/2019								
572			6/22/2019								
573			6/23/2019								
574			6/24/2019								
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576			6/26/2019								
577			6/27/2019								
578			6/28/2019								
579			6/29/2019								
580			6/30/2019								
581			7/1/2019								
582			7/2/2019								
583			7/3/2019								
584			7/4/2019								
585			7/5/2019								
586			7/6/2019								
587			7/7/2019								
588			7/8/2019								
589			7/9/2019								
590			7/10/2019								
591			7/11/2019								
592			7/12/2019								
593			7/13/2019								
594			7/14/2019								
595			7/15/2019								
596			7/16/2019								
597			7/17/2019								
598			7/18/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
599			7/19/2019								
600			7/20/2019								
601			7/21/2019								
602			7/22/2019								
603			7/23/2019								
604			7/24/2019								
605			7/25/2019								
606			7/26/2019								
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608			7/28/2019								
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610			7/30/2019								
611			7/31/2019								
612			8/1/2019								
613			8/2/2019								
614			8/3/2019								
615			8/4/2019								
616			8/5/2019								
617			8/6/2019								
618			8/7/2019								
619			8/8/2019								
620			8/9/2019								
621			8/10/2019								
622			8/11/2019								
623			8/12/2019								
624			8/13/2019								
625			8/14/2019								
626			8/15/2019								
627			8/16/2019								
628			8/17/2019								
629			8/18/2019								
630			8/19/2019								
631			8/20/2019								
632			8/21/2019								
633			8/22/2019								
634			8/23/2019								
635			8/24/2019								
636			8/25/2019								
637			8/26/2019								
638			8/27/2019								
639			8/28/2019								
640			8/29/2019								
641			8/30/2019								
642			8/31/2019								
643			9/1/2019								
644			9/2/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
645			9/3/2019								
646			9/4/2019								
647			9/5/2019								
648			9/6/2019								
649			9/7/2019								
650			9/8/2019								
651			9/9/2019								
652			9/10/2019								
653			9/11/2019								
654			9/12/2019								
655			9/13/2019								
656			9/14/2019								
657			9/15/2019								
658			9/16/2019								
659			9/17/2019								
660			9/18/2019								
661			9/19/2019								
662			9/20/2019								
663			9/21/2019								
664			9/22/2019								
665			9/23/2019								
666			9/24/2019								
667			9/25/2019								
668			9/26/2019								
669			9/27/2019								
670			9/28/2019								
671			9/29/2019								
672			9/30/2019								
673			10/1/2019								
674			10/2/2019								
675			10/3/2019								
676			10/4/2019								
677			10/5/2019								
678			10/6/2019								
679			10/7/2019								
680			10/8/2019								
681			10/9/2019								
682			10/10/2019								
683			10/11/2019								
684			10/12/2019								
685			10/13/2019								
686			10/14/2019								
687			10/15/2019								
688			10/16/2019								
689			10/17/2019								
690			10/18/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
691			10/19/2019								
692			10/20/2019								
693			10/21/2019								
694			10/22/2019								
695			10/23/2019								
696			10/24/2019								
697			10/25/2019								
698			10/26/2019								
699			10/27/2019								
700			10/28/2019								
701			10/29/2019								
702			10/30/2019								
703			10/31/2019								
704			11/1/2019								
705			11/2/2019								
706			11/3/2019								
707			11/4/2019								
708			11/5/2019								
709			11/6/2019								
710			11/7/2019								
711			11/8/2019								
712			11/9/2019								
713			11/10/2019								
714			11/11/2019								
715			11/12/2019								
716			11/13/2019								
717			11/14/2019								
718			11/15/2019								
719			11/16/2019								
720			11/17/2019								
721			11/18/2019								
722			11/19/2019								
723			11/20/2019								
724			11/21/2019								
725			11/22/2019								
726			11/23/2019								
727			11/24/2019								
728			11/25/2019								
729			11/26/2019								
730			11/27/2019								
731			11/28/2019								
732			11/29/2019								
733			11/30/2019								
734			12/1/2019								
735			12/2/2019								
736			12/3/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
737			12/4/2019								
738			12/5/2019								
739			12/6/2019								
740			12/7/2019								
741			12/8/2019								
742			12/9/2019								
743			12/10/2019								
744			12/11/2019								
745			12/12/2019								
746			12/13/2019								
747			12/14/2019								
748			12/15/2019								
749			12/16/2019								
750			12/17/2019								
751			12/18/2019								
752			12/19/2019								
753			12/20/2019								
754			12/21/2019								
755			12/22/2019								
756			12/23/2019								
757			12/24/2019								
758			12/25/2019								
759			12/26/2019								
760			12/27/2019								
761			12/28/2019								
762			12/29/2019								
763			12/30/2019								
764			12/31/2019								
765			1/1/2020								
766			1/2/2020								
767			1/3/2020								
768			1/4/2020								
769			1/5/2020								
770			1/6/2020								
771			1/7/2020								
772			1/8/2020								
773			1/9/2020								
774			1/10/2020								
775			1/11/2020								
776			1/12/2020								
777			1/13/2020								
778			1/14/2020								
779			1/15/2020								
780			1/16/2020								
781			1/17/2020								
782			1/18/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
783			1/19/2020								
784			1/20/2020								
785			1/21/2020								
786			1/22/2020								
787			1/23/2020								
788			1/24/2020								
789			1/25/2020								
790			1/26/2020								
791			1/27/2020								
792			1/28/2020								
793			1/29/2020								
794			1/30/2020								
795			1/31/2020								
796			2/1/2020								
797			2/2/2020								
798			2/3/2020								
799			2/4/2020								
800			2/5/2020								
801			2/6/2020								
802			2/7/2020								
803			2/8/2020								
804			2/9/2020								
805			2/10/2020								
806			2/11/2020								
807			2/12/2020								
808			2/13/2020								
809			2/14/2020								
810			2/15/2020								
811			2/16/2020								
812			2/17/2020								
813			2/18/2020								
814			2/19/2020								
815			2/20/2020								
816			2/21/2020								
817			2/22/2020								
818			2/23/2020								
819			2/24/2020								
820			2/25/2020								
821			2/26/2020								
822			2/27/2020								
823			2/28/2020								
824			2/29/2020								
825			3/1/2020								
826			3/2/2020								
827			3/3/2020								
828			3/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
829			3/5/2020								
830			3/6/2020								
831			3/7/2020								
832			3/8/2020								
833			3/9/2020								
834			3/10/2020								
835			3/11/2020								
836			3/12/2020								
837			3/13/2020								
838			3/14/2020								
839			3/15/2020								
840			3/16/2020								
841			3/17/2020								
842			3/18/2020								
843			3/19/2020								
844			3/20/2020								
845			3/21/2020								
846			3/22/2020								
847			3/23/2020								
848			3/24/2020								
849			3/25/2020								
850			3/26/2020								
851			3/27/2020								
852			3/28/2020								
853			3/29/2020								
854			3/30/2020								
855			3/31/2020								
856			4/1/2020								
857			4/2/2020								
858			4/3/2020								
859			4/4/2020								
860			4/5/2020								
861			4/6/2020								
862			4/7/2020								
863			4/8/2020								
864			4/9/2020								
865			4/10/2020								
866			4/11/2020								
867			4/12/2020								
868			4/13/2020								
869			4/14/2020								
870			4/15/2020								
871			4/16/2020								
872			4/17/2020								
873			4/18/2020								
874			4/19/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
875			4/20/2020								
876			4/21/2020								
877			4/22/2020								
878			4/23/2020								
879			4/24/2020								
880			4/25/2020								
881			4/26/2020								
882			4/27/2020								
883			4/28/2020								
884			4/29/2020								
885			4/30/2020								
886			5/1/2020								
887			5/2/2020								
888			5/3/2020								
889			5/4/2020								
890			5/5/2020								
891			5/6/2020								
892			5/7/2020								
893			5/8/2020								
894			5/9/2020								
895			5/10/2020								
896			5/11/2020								
897			5/12/2020								
898			5/13/2020								
899			5/14/2020								
900			5/15/2020								
901			5/16/2020								
902			5/17/2020								
903			5/18/2020								
904			5/19/2020								
905			5/20/2020								
906			5/21/2020								
907			5/22/2020								
908			5/23/2020								
909			5/24/2020								
910			5/25/2020								
911			5/26/2020								
912			5/27/2020								
913			5/28/2020								
914			5/29/2020								
915			5/30/2020								
916			5/31/2020								
917			6/1/2020								
918			6/2/2020								
919			6/3/2020								
920			6/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
921			6/5/2020								
922			6/6/2020								
923			6/7/2020								
924			6/8/2020								
925			6/9/2020								
926			6/10/2020								
927			6/11/2020								
928			6/12/2020								
929			6/13/2020								
930			6/14/2020								
931			6/15/2020								
932			6/16/2020								
933			6/17/2020								
934			6/18/2020								
935			6/19/2020								
936			6/20/2020								
937			6/21/2020								
938			6/22/2020								
939			6/23/2020								
940			6/24/2020								
941			6/25/2020								
942			6/26/2020								
943			6/27/2020								
944			6/28/2020								
945			6/29/2020								
946			6/30/2020								
947			7/1/2020								
948			7/2/2020								
949			7/3/2020								
950			7/4/2020								
951			7/5/2020								
952			7/6/2020								
953			7/7/2020								
954			7/8/2020								
955			7/9/2020								
956			7/10/2020								
957			7/11/2020								
958			7/12/2020								
959			7/13/2020								
960			7/14/2020								
961			7/15/2020								
962			7/16/2020								
963			7/17/2020								
964			7/18/2020								
965			7/19/2020								
966			7/20/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
967			7/21/2020								
968			7/22/2020								
969			7/23/2020								
970			7/24/2020								
971			7/25/2020								
972			7/26/2020								
973			7/27/2020								
974			7/28/2020								
975			7/29/2020								
976			7/30/2020								
977			7/31/2020								
978			8/1/2020								
979			8/2/2020								
980			8/3/2020								
981			8/4/2020								
982			8/5/2020								
983			8/6/2020								
984			8/7/2020								
985			8/8/2020								
986			8/9/2020								
987			8/10/2020								
988			8/11/2020								
989			8/12/2020								
990			8/13/2020								
991			8/14/2020								
992			8/15/2020								
993			8/16/2020								
994			8/17/2020								
995			8/18/2020								
996			8/19/2020								
997			8/20/2020								
998			8/21/2020								
999			8/22/2020								
1000			8/23/2020								
1001			8/24/2020								
1002			8/25/2020								
1003			8/26/2020								
1004			8/27/2020								
1005			8/28/2020								
1006			8/29/2020								
1007			8/30/2020								
1008			8/31/2020								
1009			9/1/2020								
1010			9/2/2020								
1011			9/3/2020								
1012			9/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1013			9/5/2020								
1014			9/6/2020								
1015			9/7/2020								
1016			9/8/2020								
1017			9/9/2020								
1018			9/10/2020								
1019			9/11/2020								
1020			9/12/2020								
1021			9/13/2020								
1022			9/14/2020								
1023			9/15/2020								
1024			9/16/2020								
1025			9/17/2020								
1026			9/18/2020								
1027			9/19/2020								
1028			9/20/2020								
1029			9/21/2020								
1030			9/22/2020								
1031			9/23/2020								
1032			9/24/2020								
1033			9/25/2020								
1034			9/26/2020								
1035			9/27/2020								
1036			9/28/2020								
1037			9/29/2020								
1038			9/30/2020								
1039			10/1/2020								
1040			10/2/2020								
1041			10/3/2020								
1042			10/4/2020								
1043			10/5/2020								
1044			10/6/2020								
1045			10/7/2020								
1046			10/8/2020								
1047			10/9/2020								
1048			10/10/2020								
1049			10/11/2020								
1050			10/12/2020								
1051			10/13/2020								
1052			10/14/2020								
1053			10/15/2020								
1054			10/16/2020								
1055			10/17/2020								
1056			10/18/2020								
1057			10/19/2020								
1058			10/20/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1059			10/21/2020								
1060			10/22/2020								
1061			10/23/2020								
1062			10/24/2020								
1063			10/25/2020								
1064			10/26/2020								
1065			10/27/2020								
1066			10/28/2020								
1067			10/29/2020								
1068			10/30/2020								
1069			10/31/2020								
1070			11/1/2020								
1071			11/2/2020								
1072			11/3/2020								
1073			11/4/2020								
1074			11/5/2020								
1075			11/6/2020								
1076			11/7/2020								
1077			11/8/2020								
1078			11/9/2020								
1079			11/10/2020								
1080			11/11/2020								
1081			11/12/2020								
1082			11/13/2020								
1083			11/14/2020								
1084			11/15/2020								
1085			11/16/2020								
1086			11/17/2020								
1087			11/18/2020								
1088			11/19/2020								
1089			11/20/2020								
1090			11/21/2020								
1091			11/22/2020								
1092			11/23/2020								
1093			11/24/2020								
1094			11/25/2020								
1095			11/26/2020								
1096			11/27/2020								
1097			11/28/2020								
1098			11/29/2020								
1099			11/30/2020								
1100			12/1/2020								
1101			12/2/2020								
1102			12/3/2020								
1103			12/4/2020								
1104			12/5/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1105			12/6/2020								
1106			12/7/2020								
1107			12/8/2020								
1108			12/9/2020								
1109			12/10/2020								
1110			12/11/2020								
1111			12/12/2020								
1112			12/13/2020								
1113			12/14/2020								
1114			12/15/2020								
1115			12/16/2020								
1116			12/17/2020								
1117			12/18/2020								
1118			12/19/2020								
1119			12/20/2020								
1120			12/21/2020								
1121			12/22/2020								
1122			12/23/2020								
1123			12/24/2020								
1124			12/25/2020								
1125			12/26/2020								
1126			12/27/2020								
1127			12/28/2020								
1128			12/29/2020								
1129			12/30/2020								
1130			12/31/2020								
1131			1/1/2021								
1132			1/2/2021								
1133			1/3/2021								
1134			1/4/2021								
1135			1/5/2021								
1136			1/6/2021								
1137			1/7/2021								
1138			1/8/2021								
1139			1/9/2021								
1140			1/10/2021								
1141			1/11/2021								
1142			1/12/2021								
1143			1/13/2021								
1144			1/14/2021								
1145			1/15/2021								
1146			1/16/2021								
1147			1/17/2021								
1148			1/18/2021								
1149			1/19/2021								
1150			1/20/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1151			1/21/2021								
1152			1/22/2021								
1153			1/23/2021								
1154			1/24/2021								
1155			1/25/2021								
1156			1/26/2021								
1157			1/27/2021								
1158			1/28/2021								
1159			1/29/2021								
1160			1/30/2021								
1161			1/31/2021								
1162			2/1/2021								
1163			2/2/2021								
1164			2/3/2021								
1165			2/4/2021								
1166			2/5/2021								
1167			2/6/2021								
1168			2/7/2021								
1169			2/8/2021								
1170			2/9/2021								
1171			2/10/2021								
1172			2/11/2021								
1173			2/12/2021								
1174			2/13/2021								
1175			2/14/2021								
1176			2/15/2021								
1177			2/16/2021								
1178			2/17/2021								
1179			2/18/2021								
1180			2/19/2021								
1181			2/20/2021								
1182			2/21/2021								
1183			2/22/2021								
1184			2/23/2021								
1185			2/24/2021								
1186			2/25/2021								
1187			2/26/2021								
1188			2/27/2021								
1189			2/28/2021								
1190			3/1/2021								
1191			3/2/2021								
1192			3/3/2021								
1193			3/4/2021								
1194			3/5/2021								
1195			3/6/2021								
1196			3/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1197			3/8/2021								
1198			3/9/2021								
1199			3/10/2021								
1200			3/11/2021								
1201			3/12/2021								
1202			3/13/2021								
1203			3/14/2021								
1204			3/15/2021								
1205			3/16/2021								
1206			3/17/2021								
1207			3/18/2021								
1208			3/19/2021								
1209			3/20/2021								
1210			3/21/2021								
1211			3/22/2021								
1212			3/23/2021								
1213			3/24/2021								
1214			3/25/2021								
1215			3/26/2021								
1216			3/27/2021								
1217			3/28/2021								
1218			3/29/2021								
1219			3/30/2021								
1220			3/31/2021								
1221			4/1/2021								
1222			4/2/2021								
1223			4/3/2021								
1224			4/4/2021								
1225			4/5/2021								
1226			4/6/2021								
1227			4/7/2021								
1228			4/8/2021								
1229			4/9/2021								
1230			4/10/2021								
1231			4/11/2021								
1232			4/12/2021								
1233			4/13/2021								
1234			4/14/2021								
1235			4/15/2021								
1236			4/16/2021								
1237			4/17/2021								
1238			4/18/2021								
1239			4/19/2021								
1240			4/20/2021								
1241			4/21/2021								
1242			4/22/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1243			4/23/2021								
1244			4/24/2021								
1245			4/25/2021								
1246			4/26/2021								
1247			4/27/2021								
1248			4/28/2021								
1249			4/29/2021								
1250			4/30/2021								
1251			5/1/2021								
1252			5/2/2021								
1253			5/3/2021								
1254			5/4/2021								
1255			5/5/2021								
1256			5/6/2021								
1257			5/7/2021								
1258			5/8/2021								
1259			5/9/2021								
1260			5/10/2021								
1261			5/11/2021								
1262			5/12/2021								
1263			5/13/2021								
1264			5/14/2021								
1265			5/15/2021								
1266			5/16/2021								
1267			5/17/2021								
1268			5/18/2021								
1269			5/19/2021								
1270			5/20/2021								
1271			5/21/2021								
1272			5/22/2021								
1273			5/23/2021								
1274			5/24/2021								
1275			5/25/2021								
1276			5/26/2021								
1277			5/27/2021								
1278			5/28/2021								
1279			5/29/2021								
1280			5/30/2021								
1281			5/31/2021								
1282			6/1/2021								
1283			6/2/2021								
1284			6/3/2021								
1285			6/4/2021								
1286			6/5/2021								
1287			6/6/2021								
1288			6/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1289			6/8/2021								
1290			6/9/2021								
1291			6/10/2021								
1292			6/11/2021								
1293			6/12/2021								
1294			6/13/2021								
1295			6/14/2021								
1296			6/15/2021								
1297			6/16/2021								
1298			6/17/2021								
1299			6/18/2021								
1300			6/19/2021								
1301			6/20/2021								
1302			6/21/2021								
1303			6/22/2021								
1304			6/23/2021								
1305			6/24/2021								
1306			6/25/2021								
1307			6/26/2021								
1308			6/27/2021								
1309			6/28/2021								
1310			6/29/2021								
1311			6/30/2021								
1312			7/1/2021								
1313			7/2/2021								
1314			7/3/2021								
1315			7/4/2021								
1316			7/5/2021								
1317			7/6/2021								
1318			7/7/2021								
1319			7/8/2021								
1320			7/9/2021								
1321			7/10/2021								
1322			7/11/2021								
1323			7/12/2021								
1324			7/13/2021								
1325			7/14/2021								
1326			7/15/2021								
1327			7/16/2021								
1328			7/17/2021								
1329			7/18/2021								
1330			7/19/2021								
1331			7/20/2021								
1332			7/21/2021								
1333			7/22/2021								
1334			7/23/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1335			7/24/2021								
1336			7/25/2021								
1337			7/26/2021								
1338			7/27/2021								
1339			7/28/2021								
1340			7/29/2021								
1341			7/30/2021								
1342			7/31/2021								
1343			8/1/2021								
1344			8/2/2021								
1345			8/3/2021								
1346			8/4/2021								
1347			8/5/2021								
1348			8/6/2021								
1349			8/7/2021								
1350			8/8/2021								
1351			8/9/2021								
1352			8/10/2021								
1353			8/11/2021								
1354			8/12/2021								
1355			8/13/2021								
1356			8/14/2021								
1357			8/15/2021								
1358			8/16/2021								
1359			8/17/2021								
1360			8/18/2021								
1361			8/19/2021								
1362			8/20/2021								
1363			8/21/2021								
1364			8/22/2021								
1365			8/23/2021								
1366			8/24/2021								
1367			8/25/2021								
1368			8/26/2021								
1369			8/27/2021								
1370			8/28/2021								
1371			8/29/2021								
1372			8/30/2021								
1373			8/31/2021								
1374			9/1/2021								
1375			9/2/2021								
1376			9/3/2021								
1377			9/4/2021								
1378			9/5/2021								
1379			9/6/2021								
1380			9/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1381			9/8/2021								
1382			9/9/2021								
1383			9/10/2021								
1384			9/11/2021								
1385			9/12/2021								
1386			9/13/2021								
1387			9/14/2021								
1388			9/15/2021								
1389			9/16/2021								
1390			9/17/2021								
1391			9/18/2021								
1392			9/19/2021								
1393			9/20/2021								
1394			9/21/2021								
1395			9/22/2021								
1396			9/23/2021								
1397			9/24/2021								
1398			9/25/2021								
1399			9/26/2021								
1400			9/27/2021								
1401			9/28/2021								
1402			9/29/2021								
1403			9/30/2021								
1404			10/1/2021								
1405			10/2/2021								
1406			10/3/2021								
1407			10/4/2021								
1408			10/5/2021								
1409			10/6/2021								
1410			10/7/2021								
1411			10/8/2021								
1412			10/9/2021								
1413			10/10/2021								
1414			10/11/2021								
1415			10/12/2021								
1416			10/13/2021								
1417			10/14/2021								
1418			10/15/2021								
1419			10/16/2021								
1420			10/17/2021								
1421			10/18/2021								
1422			10/19/2021								
1423			10/20/2021								
1424			10/21/2021								
1425			10/22/2021								
1426			10/23/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1427			10/24/2021								
1428			10/25/2021								
1429			10/26/2021								
1430			10/27/2021								
1431			10/28/2021								
1432			10/29/2021								
1433			10/30/2021								
1434			10/31/2021								
1435			11/1/2021								
1436			11/2/2021								
1437			11/3/2021								
1438			11/4/2021								
1439			11/5/2021								
1440			11/6/2021								
1441			11/7/2021								
1442			11/8/2021								
1443			11/9/2021								
1444			11/10/2021								
1445			11/11/2021								
1446			11/12/2021								
1447			11/13/2021								
1448			11/14/2021								
1449			11/15/2021								
1450			11/16/2021								
1451			11/17/2021								
1452			11/18/2021								
1453			11/19/2021								
1454			11/20/2021								
1455			11/21/2021								
1456			11/22/2021								
1457			11/23/2021								
1458			11/24/2021								
1459			11/25/2021								
1460			11/26/2021								
1461			11/27/2021								
1462			11/28/2021								
1463			11/29/2021								
1464			11/30/2021								
1465			12/1/2021								
1466			12/2/2021								
1467			12/3/2021								
1468			12/4/2021								
1469			12/5/2021								
1470			12/6/2021								
1471			12/7/2021								
1472			12/8/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1473			12/9/2021								
1474			12/10/2021								
1475			12/11/2021								
1476			12/12/2021								
1477			12/13/2021								
1478			12/14/2021								
1479			12/15/2021								
1480			12/16/2021								
1481			12/17/2021								
1482			12/18/2021								
1483			12/19/2021								
1484			12/20/2021								
1485			12/21/2021								
1486			12/22/2021								
1487			12/23/2021								
1488			12/24/2021								
1489			12/25/2021								
1490			12/26/2021								
1491			12/27/2021								
1492			12/28/2021								
1493			12/29/2021								
1494			12/30/2021								
1495			12/31/2021								
1496			1/1/2022								
1497			1/2/2022								
1498			1/3/2022								
1499			1/4/2022								
1500			1/5/2022								
1501			1/6/2022								
1502			1/7/2022								
1503			1/8/2022								
1504			1/9/2022								
1505			1/10/2022								
1506			1/11/2022								
1507			1/12/2022								
1508			1/13/2022								
1509			1/14/2022								
1510			1/15/2022								
1511			1/16/2022								
1512			1/17/2022								
1513			1/18/2022								
1514			1/19/2022								
1515			1/20/2022								
1516			1/21/2022								
1517			1/22/2022								
1518			1/23/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1519			1/24/2022								
1520			1/25/2022								
1521			1/26/2022								
1522			1/27/2022								
1523			1/28/2022								
1524			1/29/2022								
1525			1/30/2022								
1526			1/31/2022								
1527			2/1/2022								
1528			2/2/2022								
1529			2/3/2022								
1530			2/4/2022								
1531			2/5/2022								
1532			2/6/2022								
1533			2/7/2022								
1534			2/8/2022								
1535			2/9/2022								
1536			2/10/2022								
1537			2/11/2022								
1538			2/12/2022								
1539			2/13/2022								
1540			2/14/2022								
1541			2/15/2022								
1542			2/16/2022								
1543			2/17/2022								
1544			2/18/2022								
1545			2/19/2022								
1546			2/20/2022								
1547			2/21/2022								
1548			2/22/2022								
1549			2/23/2022								
1550			2/24/2022								
1551			2/25/2022								
1552			2/26/2022								
1553			2/27/2022								
1554			2/28/2022								
1555			3/1/2022								
1556			3/2/2022								
1557			3/3/2022								
1558			3/4/2022								
1559			3/5/2022								
1560			3/6/2022								
1561			3/7/2022								
1562			3/8/2022								
1563			3/9/2022								
1564			3/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1565			3/11/2022								
1566			3/12/2022								
1567			3/13/2022								
1568			3/14/2022								
1569			3/15/2022								
1570			3/16/2022								
1571			3/17/2022								
1572			3/18/2022								
1573			3/19/2022								
1574			3/20/2022								
1575			3/21/2022								
1576			3/22/2022								
1577			3/23/2022								
1578			3/24/2022								
1579			3/25/2022								
1580			3/26/2022								
1581			3/27/2022								
1582			3/28/2022								
1583			3/29/2022								
1584			3/30/2022								
1585			3/31/2022								
1586			4/1/2022								
1587			4/2/2022								
1588			4/3/2022								
1589			4/4/2022								
1590			4/5/2022								
1591			4/6/2022								
1592			4/7/2022								
1593			4/8/2022								
1594			4/9/2022								
1595			4/10/2022								
1596			4/11/2022								
1597			4/12/2022								
1598			4/13/2022								
1599			4/14/2022								
1600			4/15/2022								
1601			4/16/2022								
1602			4/17/2022								
1603			4/18/2022								
1604			4/19/2022								
1605			4/20/2022								
1606			4/21/2022								
1607			4/22/2022								
1608			4/23/2022								
1609			4/24/2022								
1610			4/25/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1611			4/26/2022								
1612			4/27/2022								
1613			4/28/2022								
1614			4/29/2022								
1615			4/30/2022								
1616			5/1/2022								
1617			5/2/2022								
1618			5/3/2022								
1619			5/4/2022								
1620			5/5/2022								
1621			5/6/2022								
1622			5/7/2022								
1623			5/8/2022								
1624			5/9/2022								
1625			5/10/2022								
1626			5/11/2022								
1627			5/12/2022								
1628			5/13/2022								
1629			5/14/2022								
1630			5/15/2022								
1631			5/16/2022								
1632			5/17/2022								
1633			5/18/2022								
1634			5/19/2022								
1635			5/20/2022								
1636			5/21/2022								
1637			5/22/2022								
1638			5/23/2022								
1639			5/24/2022								
1640			5/25/2022								
1641			5/26/2022								
1642			5/27/2022								
1643			5/28/2022								
1644			5/29/2022								
1645			5/30/2022								
1646			5/31/2022								
1647			6/1/2022								
1648			6/2/2022								
1649			6/3/2022								
1650			6/4/2022								
1651			6/5/2022								
1652			6/6/2022								
1653			6/7/2022								
1654			6/8/2022								
1655			6/9/2022								
1656			6/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1657			6/11/2022								
1658			6/12/2022								
1659			6/13/2022								
1660			6/14/2022								
1661			6/15/2022								
1662			6/16/2022								
1663			6/17/2022								
1664			6/18/2022								
1665			6/19/2022								
1666			6/20/2022								
1667			6/21/2022								
1668			6/22/2022								
1669			6/23/2022								
1670			6/24/2022								
1671			6/25/2022								
1672			6/26/2022								
1673			6/27/2022								
1674			6/28/2022								
1675			6/29/2022								
1676			6/30/2022								
1677			7/1/2022								
1678			7/2/2022								
1679			7/3/2022								
1680			7/4/2022								
1681			7/5/2022								
1682			7/6/2022								
1683			7/7/2022								
1684			7/8/2022								
1685			7/9/2022								
1686			7/10/2022								
1687			7/11/2022								
1688			7/12/2022								
1689			7/13/2022								
1690			7/14/2022								
1691			7/15/2022								
1692			7/16/2022								
1693			7/17/2022								
1694			7/18/2022								
1695			7/19/2022								
1696			7/20/2022								
1697			7/21/2022								
1698			7/22/2022								
1699			7/23/2022								
1700			7/24/2022								
1701			7/25/2022								
1702			7/26/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1703			7/27/2022								
1704			7/28/2022								
1705			7/29/2022								
1706			7/30/2022								
1707			7/31/2022								
1708			8/1/2022								
1709			8/2/2022								
1710			8/3/2022								
1711			8/4/2022								
1712			8/5/2022								
1713			8/6/2022								
1714			8/7/2022								
1715			8/8/2022								
1716			8/9/2022								
1717			8/10/2022								
1718			8/11/2022								
1719			8/12/2022								
1720			8/13/2022								
1721			8/14/2022								
1722			8/15/2022								
1723			8/16/2022								
1724			8/17/2022								
1725			8/18/2022								
1726			8/19/2022								
1727			8/20/2022								
1728			8/21/2022								
1729			8/22/2022								
1730			8/23/2022								
1731			8/24/2022								
1732			8/25/2022								
1733			8/26/2022								
1734			8/27/2022								
1735			8/28/2022								
1736			8/29/2022								
1737			8/30/2022								
1738			8/31/2022								
1739			9/1/2022								
1740			9/2/2022								
1741			9/3/2022								
1742			9/4/2022								
1743			9/5/2022								
1744			9/6/2022								
1745			9/7/2022								
1746			9/8/2022								
1747			9/9/2022								
1748			9/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1749			9/11/2022								
1750			9/12/2022								
1751			9/13/2022								
1752			9/14/2022								
1753			9/15/2022								
1754			9/16/2022								
1755			9/17/2022								
1756			9/18/2022								
1757			9/19/2022								
1758			9/20/2022								
1759			9/21/2022								
1760			9/22/2022								
1761			9/23/2022								
1762			9/24/2022								
1763			9/25/2022								
1764			9/26/2022								
1765			9/27/2022								
1766			9/28/2022								
1767			9/29/2022								
1768			9/30/2022								
1769			10/1/2022								
1770			10/2/2022								
1771			10/3/2022								
1772			10/4/2022								
1773			10/5/2022								
1774			10/6/2022								
1775			10/7/2022								
1776			10/8/2022								
1777			10/9/2022								
1778			10/10/2022								
1779			10/11/2022								
1780			10/12/2022								
1781			10/13/2022								
1782			10/14/2022								
1783			10/15/2022								
1784			10/16/2022								
1785			10/17/2022								
1786			10/18/2022								
1787			10/19/2022								
1788			10/20/2022								
1789			10/21/2022								
1790			10/22/2022								
1791			10/23/2022								
1792			10/24/2022								
1793			10/25/2022								
1794			10/26/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1795			10/27/2022								
1796			10/28/2022								
1797			10/29/2022								
1798			10/30/2022								
1799			10/31/2022								
1800			11/1/2022								
1801			11/2/2022								
1802			11/3/2022								
1803			11/4/2022								
1804			11/5/2022								
1805			11/6/2022								
1806			11/7/2022								
1807			11/8/2022								
1808			11/9/2022								
1809			11/10/2022								
1810			11/11/2022								
1811			11/12/2022								
1812			11/13/2022								
1813			11/14/2022								
1814			11/15/2022								
1815			11/16/2022								
1816			11/17/2022								
1817			11/18/2022								
1818			11/19/2022								
1819			11/20/2022								
1820			11/21/2022								
1821			11/22/2022								
1822			11/23/2022								
1823			11/24/2022								
1824			11/25/2022								
1825			11/26/2022								
1826			11/27/2022								
1827			11/28/2022								
1828			11/29/2022								
1829			11/30/2022								
1830			12/1/2022								
1831			12/2/2022								
1832			12/3/2022								
1833			12/4/2022								
1834			12/5/2022								
1835			12/6/2022								
1836			12/7/2022								
1837			12/8/2022								
1838			12/9/2022								
1839			12/10/2022								
1840			12/11/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1841			12/12/2022								
1842			12/13/2022								
1843			12/14/2022								
1844			12/15/2022								
1845			12/16/2022								
1846			12/17/2022								
1847			12/18/2022								
1848			12/19/2022								
1849			12/20/2022								
1850			12/21/2022								
1851			12/22/2022								
1852			12/23/2022								
1853			12/24/2022								
1854			12/25/2022								
1855			12/26/2022								
1856			12/27/2022								
1857			12/28/2022								
1858			12/29/2022								
1859			12/30/2022								
1860			12/31/2022								
1861			1/1/2023								
1862			1/2/2023								
1863			1/3/2023								
1864			1/4/2023								
1865			1/5/2023								
1866			1/6/2023								
1867			1/7/2023								
1868			1/8/2023								
1869			1/9/2023								
1870			1/10/2023								
1871			1/11/2023								
1872			1/12/2023								
1873			1/13/2023								
1874			1/14/2023								
1875			1/15/2023								
1876			1/16/2023								
1877			1/17/2023								
1878			1/18/2023								
1879			1/19/2023								
1880			1/20/2023								
1881			1/21/2023								
1882			1/22/2023								
1883			1/23/2023								
1884			1/24/2023								
1885			1/25/2023								
1886			1/26/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1887			1/27/2023								
1888			1/28/2023								
1889			1/29/2023								
1890			1/30/2023								
1891			1/31/2023								
1892			2/1/2023								
1893			2/2/2023								
1894			2/3/2023								
1895			2/4/2023								
1896			2/5/2023								
1897			2/6/2023								
1898			2/7/2023								
1899			2/8/2023								
1900			2/9/2023								
1901			2/10/2023								
1902			2/11/2023								
1903			2/12/2023								
1904			2/13/2023								
1905			2/14/2023								
1906			2/15/2023								
1907			2/16/2023								
1908			2/17/2023								
1909			2/18/2023								
1910			2/19/2023								
1911			2/20/2023								
1912			2/21/2023								
1913			2/22/2023								
1914			2/23/2023								
1915			2/24/2023								
1916			2/25/2023								
1917			2/26/2023								
1918			2/27/2023								
1919			2/28/2023								
1920			3/1/2023								
1921			3/2/2023								
1922			3/3/2023								
1923			3/4/2023								
1924			3/5/2023								
1925			3/6/2023								
1926			3/7/2023								
1927			3/8/2023								
1928			3/9/2023								
1929			3/10/2023								
1930			3/11/2023								
1931			3/12/2023								
1932			3/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1933			3/14/2023								
1934			3/15/2023								
1935			3/16/2023								
1936			3/17/2023								
1937			3/18/2023								
1938			3/19/2023								
1939			3/20/2023								
1940			3/21/2023								
1941			3/22/2023								
1942			3/23/2023								
1943			3/24/2023								
1944			3/25/2023								
1945			3/26/2023								
1946			3/27/2023								
1947			3/28/2023								
1948			3/29/2023								
1949			3/30/2023								
1950			3/31/2023								
1951			4/1/2023								
1952			4/2/2023								
1953			4/3/2023								
1954			4/4/2023								
1955			4/5/2023								
1956			4/6/2023								
1957			4/7/2023								
1958			4/8/2023								
1959			4/9/2023								
1960			4/10/2023								
1961			4/11/2023								
1962			4/12/2023								
1963			4/13/2023								
1964			4/14/2023								
1965			4/15/2023								
1966			4/16/2023								
1967			4/17/2023								
1968			4/18/2023								
1969			4/19/2023								
1970			4/20/2023								
1971			4/21/2023								
1972			4/22/2023								
1973			4/23/2023								
1974			4/24/2023								
1975			4/25/2023								
1976			4/26/2023								
1977			4/27/2023								
1978			4/28/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1979			4/29/2023								
1980			4/30/2023								
1981			5/1/2023								
1982			5/2/2023								
1983			5/3/2023								
1984			5/4/2023								
1985			5/5/2023								
1986			5/6/2023								
1987			5/7/2023								
1988			5/8/2023								
1989			5/9/2023								
1990			5/10/2023								
1991			5/11/2023								
1992			5/12/2023								
1993			5/13/2023								
1994			5/14/2023								
1995			5/15/2023								
1996			5/16/2023								
1997			5/17/2023								
1998			5/18/2023								
1999			5/19/2023								
2000			5/20/2023								
2001			5/21/2023								
2002			5/22/2023								
2003			5/23/2023								
2004			5/24/2023								
2005			5/25/2023								
2006			5/26/2023								
2007			5/27/2023								
2008			5/28/2023								
2009			5/29/2023								
2010			5/30/2023								
2011			5/31/2023								
2012			6/1/2023								
2013			6/2/2023								
2014			6/3/2023								
2015			6/4/2023								
2016			6/5/2023								
2017			6/6/2023								
2018			6/7/2023								
2019			6/8/2023								
2020			6/9/2023								
2021			6/10/2023								
2022			6/11/2023								
2023			6/12/2023								
2024			6/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2025			6/14/2023								
2026			6/15/2023								
2027			6/16/2023								
2028			6/17/2023								
2029			6/18/2023								
2030			6/19/2023								
2031			6/20/2023								
2032			6/21/2023								
2033			6/22/2023								
2034			6/23/2023								
2035			6/24/2023								
2036			6/25/2023								
2037			6/26/2023								
2038			6/27/2023								
2039			6/28/2023								
2040			6/29/2023								
2041			6/30/2023								
2042			7/1/2023								
2043			7/2/2023								
2044			7/3/2023								
2045			7/4/2023								
2046			7/5/2023								
2047			7/6/2023								
2048			7/7/2023								
2049			7/8/2023								
2050			7/9/2023								
2051			7/10/2023								
2052			7/11/2023								
2053			7/12/2023								
2054			7/13/2023								
2055			7/14/2023								
2056			7/15/2023								
2057			7/16/2023								
2058			7/17/2023								
2059			7/18/2023								
2060			7/19/2023								
2061			7/20/2023								
2062			7/21/2023								
2063			7/22/2023								
2064			7/23/2023								
2065			7/24/2023								
2066			7/25/2023								
2067			7/26/2023								
2068			7/27/2023								
2069			7/28/2023								
2070			7/29/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2071			7/30/2023								
2072			7/31/2023								
2073			8/1/2023								
2074			8/2/2023								
2075			8/3/2023								
2076			8/4/2023								
2077			8/5/2023								
2078			8/6/2023								
2079			8/7/2023								
2080			8/8/2023								
2081			8/9/2023								
2082			8/10/2023								
2083			8/11/2023								
2084			8/12/2023								
2085			8/13/2023								
2086			8/14/2023								
2087			8/15/2023								
2088			8/16/2023								
2089			8/17/2023								
2090			8/18/2023								
2091			8/19/2023								
2092			8/20/2023								
2093			8/21/2023								
2094			8/22/2023								
2095			8/23/2023								
2096			8/24/2023								
2097			8/25/2023								
2098			8/26/2023								
2099			8/27/2023								
2100			8/28/2023								
2101			8/29/2023								
2102			8/30/2023								
2103			8/31/2023								
2104			9/1/2023								
2105			9/2/2023								
2106			9/3/2023								
2107			9/4/2023								
2108			9/5/2023								
2109			9/6/2023								
2110			9/7/2023								
2111			9/8/2023								
2112			9/9/2023								
2113			9/10/2023								
2114			9/11/2023								
2115			9/12/2023								
2116			9/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2117			9/14/2023								
2118			9/15/2023								
2119			9/16/2023								
2120			9/17/2023								
2121			9/18/2023								
2122			9/19/2023								
2123			9/20/2023								
2124			9/21/2023								
2125			9/22/2023								
2126			9/23/2023								
2127			9/24/2023								
2128			9/25/2023								
2129			9/26/2023								
2130			9/27/2023								
2131			9/28/2023								
2132			9/29/2023								
2133			9/30/2023								
2134			10/1/2023								
2135			10/2/2023								
2136			10/3/2023								
2137			10/4/2023								
2138			10/5/2023								
2139			10/6/2023								
2140			10/7/2023								
2141			10/8/2023								
2142			10/9/2023								
2143			10/10/2023								
2144			10/11/2023								
2145			10/12/2023								
2146			10/13/2023								
2147			10/14/2023								
2148			10/15/2023								
2149			10/16/2023								
2150			10/17/2023								
2151			10/18/2023								
2152			10/19/2023								
2153			10/20/2023								
2154			10/21/2023								
2155			10/22/2023								
2156			10/23/2023								
2157			10/24/2023								
2158			10/25/2023								
2159			10/26/2023								
2160			10/27/2023								
2161			10/28/2023								
2162			10/29/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2163			10/30/2023								
2164			10/31/2023								
2165			11/1/2023								
2166			11/2/2023								
2167			11/3/2023								
2168			11/4/2023								
2169			11/5/2023								
2170			11/6/2023								
2171			11/7/2023								
2172			11/8/2023								
2173			11/9/2023								
2174			11/10/2023								
2175			11/11/2023								
2176			11/12/2023								
2177			11/13/2023								
2178			11/14/2023								
2179			11/15/2023								
2180			11/16/2023								
2181			11/17/2023								
2182			11/18/2023								
2183			11/19/2023								
2184			11/20/2023								
2185			11/21/2023								
2186			11/22/2023								
2187			11/23/2023								
2188			11/24/2023								
2189			11/25/2023								
2190			11/26/2023								
2191			11/27/2023								
2192			11/28/2023								
2193			11/29/2023								
2194			11/30/2023								
2195			12/1/2023								
2196			12/2/2023								
2197			12/3/2023								
2198			12/4/2023								
2199			12/5/2023								
2200			12/6/2023								
2201			12/7/2023								
2202			12/8/2023								
2203			12/9/2023								
2204			12/10/2023								
2205			12/11/2023								
2206			12/12/2023								
2207			12/13/2023								
2208			12/14/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2209			12/15/2023								
2210			12/16/2023								
2211			12/17/2023								
2212			12/18/2023								
2213			12/19/2023								
2214			12/20/2023								
2215			12/21/2023								
2216			12/22/2023								
2217			12/23/2023								
2218			12/24/2023								
2219			12/25/2023								
2220			12/26/2023								
2221			12/27/2023								
2222			12/28/2023								
2223			12/29/2023								
2224			12/30/2023								
2225			12/31/2023								
2226			1/1/2024								
2227			1/2/2024								
2228			1/3/2024								
2229			1/4/2024								
2230			1/5/2024								
2231			1/6/2024								
2232			1/7/2024								
2233			1/8/2024								
2234			1/9/2024								
2235			1/10/2024								
2236			1/11/2024								
2237			1/12/2024								
2238			1/13/2024								
2239			1/14/2024								
2240			1/15/2024								
2241			1/16/2024								
2242			1/17/2024								
2243			1/18/2024								
2244			1/19/2024								
2245			1/20/2024								
2246			1/21/2024								
2247			1/22/2024								
2248			1/23/2024								
2249			1/24/2024								
2250			1/25/2024								
2251			1/26/2024								
2252			1/27/2024								
2253			1/28/2024								
2254			1/29/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2255			1/30/2024								
2256			1/31/2024								
2257			2/1/2024								
2258			2/2/2024								
2259			2/3/2024								
2260			2/4/2024								
2261			2/5/2024								
2262			2/6/2024								
2263			2/7/2024								
2264			2/8/2024								
2265			2/9/2024								
2266			2/10/2024								
2267			2/11/2024								
2268			2/12/2024								
2269			2/13/2024								
2270			2/14/2024								
2271			2/15/2024								
2272			2/16/2024								
2273			2/17/2024								
2274			2/18/2024								
2275			2/19/2024								
2276			2/20/2024								
2277			2/21/2024								
2278			2/22/2024								
2279			2/23/2024								
2280			2/24/2024								
2281			2/25/2024								
2282			2/26/2024								
2283			2/27/2024								
2284			2/28/2024								
2285			2/29/2024								
2286			3/1/2024								
2287			3/2/2024								
2288			3/3/2024								
2289			3/4/2024								
2290			3/5/2024								
2291			3/6/2024								
2292			3/7/2024								
2293			3/8/2024								
2294			3/9/2024								
2295			3/10/2024								
2296			3/11/2024								
2297			3/12/2024								
2298			3/13/2024								
2299			3/14/2024								
2300			3/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2301			3/16/2024								
2302			3/17/2024								
2303			3/18/2024								
2304			3/19/2024								
2305			3/20/2024								
2306			3/21/2024								
2307			3/22/2024								
2308			3/23/2024								
2309			3/24/2024								
2310			3/25/2024								
2311			3/26/2024								
2312			3/27/2024								
2313			3/28/2024								
2314			3/29/2024								
2315			3/30/2024								
2316			3/31/2024								
2317			4/1/2024								
2318			4/2/2024								
2319			4/3/2024								
2320			4/4/2024								
2321			4/5/2024								
2322			4/6/2024								
2323			4/7/2024								
2324			4/8/2024								
2325			4/9/2024								
2326			4/10/2024								
2327			4/11/2024								
2328			4/12/2024								
2329			4/13/2024								
2330			4/14/2024								
2331			4/15/2024								
2332			4/16/2024								
2333			4/17/2024								
2334			4/18/2024								
2335			4/19/2024								
2336			4/20/2024								
2337			4/21/2024								
2338			4/22/2024								
2339			4/23/2024								
2340			4/24/2024								
2341			4/25/2024								
2342			4/26/2024								
2343			4/27/2024								
2344			4/28/2024								
2345			4/29/2024								
2346			4/30/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2347			5/1/2024								
2348			5/2/2024								
2349			5/3/2024								
2350			5/4/2024								
2351			5/5/2024								
2352			5/6/2024								
2353			5/7/2024								
2354			5/8/2024								
2355			5/9/2024								
2356			5/10/2024								
2357			5/11/2024								
2358			5/12/2024								
2359			5/13/2024								
2360			5/14/2024								
2361			5/15/2024								
2362			5/16/2024								
2363			5/17/2024								
2364			5/18/2024								
2365			5/19/2024								
2366			5/20/2024								
2367			5/21/2024								
2368			5/22/2024								
2369			5/23/2024								
2370			5/24/2024								
2371			5/25/2024								
2372			5/26/2024								
2373			5/27/2024								
2374			5/28/2024								
2375			5/29/2024								
2376			5/30/2024								
2377			5/31/2024								
2378			6/1/2024								
2379			6/2/2024								
2380			6/3/2024								
2381			6/4/2024								
2382			6/5/2024								
2383			6/6/2024								
2384			6/7/2024								
2385			6/8/2024								
2386			6/9/2024								
2387			6/10/2024								
2388			6/11/2024								
2389			6/12/2024								
2390			6/13/2024								
2391			6/14/2024								
2392			6/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2393			6/16/2024								
2394			6/17/2024								
2395			6/18/2024								
2396			6/19/2024								
2397			6/20/2024								
2398			6/21/2024								
2399			6/22/2024								
2400			6/23/2024								
2401			6/24/2024								
2402			6/25/2024								
2403			6/26/2024								
2404			6/27/2024								
2405			6/28/2024								
2406			6/29/2024								
2407			6/30/2024								
2408			7/1/2024								
2409			7/2/2024								
2410			7/3/2024								
2411			7/4/2024								
2412			7/5/2024								
2413			7/6/2024								
2414			7/7/2024								
2415			7/8/2024								
2416			7/9/2024								
2417			7/10/2024								
2418			7/11/2024								
2419			7/12/2024								
2420			7/13/2024								
2421			7/14/2024								
2422			7/15/2024								
2423			7/16/2024								
2424			7/17/2024								
2425			7/18/2024								
2426			7/19/2024								
2427			7/20/2024								
2428			7/21/2024								
2429			7/22/2024								
2430			7/23/2024								
2431			7/24/2024								
2432			7/25/2024								
2433			7/26/2024								
2434			7/27/2024								
2435			7/28/2024								
2436			7/29/2024								
2437			7/30/2024								
2438			7/31/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2439			8/1/2024								
2440			8/2/2024								
2441			8/3/2024								
2442			8/4/2024								
2443			8/5/2024								
2444			8/6/2024								
2445			8/7/2024								
2446			8/8/2024								
2447			8/9/2024								
2448			8/10/2024								
2449			8/11/2024								
2450			8/12/2024								
2451			8/13/2024								
2452			8/14/2024								
2453			8/15/2024								
2454			8/16/2024								
2455			8/17/2024								
2456			8/18/2024								
2457			8/19/2024								
2458			8/20/2024								
2459			8/21/2024								
2460			8/22/2024								
2461			8/23/2024								
2462			8/24/2024								
2463			8/25/2024								
2464			8/26/2024								
2465			8/27/2024								
2466			8/28/2024								
2467			8/29/2024								
2468			8/30/2024								
2469			8/31/2024								
2470			9/1/2024								
2471			9/2/2024								
2472			9/3/2024								
2473			9/4/2024								
2474			9/5/2024								
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2484			9/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2485			9/16/2024								
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2531			11/1/2024								
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2623			2/1/2025								
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AMERICAN OVERSIGHT

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2669			3/19/2025								
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2715			5/4/2025								
2716			5/5/2025								
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2760			6/18/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2761			6/19/2025								
2762			6/20/2025								
2763			6/21/2025								
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2803			7/31/2025								
2804			8/1/2025								
2805			8/2/2025								
2806			8/3/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2807			8/4/2025								
2808			8/5/2025								
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2850			9/16/2025								
2851			9/17/2025								
2852			9/18/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2853			9/19/2025								
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2896			11/1/2025								
2897			11/2/2025								
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2899			11/4/2025								
2900			11/5/2025								
2901			11/6/2025								
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2944			12/19/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2945			12/20/2025								
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2956			12/31/2025								

AMERICAN OVERSIGHT

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

					*Indicates Required Field	
Facility Information						
Facility Name:*	Rio Grande Detention Center					
AOR:*	SNA					
Address:	1001 San Rio Blvd.					
City:	Laredo		**County:**	Webb		
State:*	TX	**Zip:**		78046		
Inspection Information						
Start Date:*	12/17/2019					
End Date:*	12/20/2019					
Organization:*		IHSC				
# Detainees at Time of Visit:		299				
Total Facility Population at Time of Visit:		1446				
Facility Capacity:		1900				
Notes:						
Reviewer Information						
Lead Reviewer Name:*	b(6); b(7)(C)			**Date Signed:***	1/29/2020	
Signature:	X					
HQ Use Only:				*5/20/2019*		

AMERICAN OVERSIGHT

	A	B	C	D
1		**Compliance Dashboard**		
2	**Subject Area**	**Description**	**Compliance**	
3	ASM	Asthma	97%	
4	CG	Complaints and Grievance	3	*Total Number
5	CM	Continuity of Medications	80%	
6	DC	Dental Care	100%	
7	DM	Diabetes	76%	
8	DSA	Diagnostic Services and Specialty Care Access	65%	
9	EED	Evaluation of Care Prior to Emergency Department	76%	
10	HA	Health Assessment	82%	
11	HIV	Human Immunodeficiency Virus	40%	
12	HTN	Hypertension	63%	
13	LT	Laboratory Testing	44%	
14	MR	Medical Recordkeeping	99%	
15	MAR	Medication Administration Records	0%	
16	MHS	Mental Health Screen	100%	
17	MHT	Mental Health Treatment Planning	93%	
18	PG	Pregnant Women		
19	SZ	Seizure Disorder	45%	
20	SS	Suicide Screening		
21	TD	Treatment of Disability	100%	
22	UC	Urgent Care (Sick Call)	95%	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**IGSA STAFFING MATRIX**			
2							
3							
4	**Position**	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
5							
6	**C.N.A.**						
7	**Dental Assistant**						
8	**Dentist**						
9	**EMT**						
10	**H.S.A.**						
11	**LVN/LPN**						
12	**MH Counselor**						
13	**MRT**						
14	**NP/PA**						
15	**Nurse Manager**						
16	**Paramedic**						
17	**Pharmacist**						
18	**Pharmacy Tech**						
19	**Physician**						
20	**Psychiatrist**						
21	**Psychologist**						
22	**RN**						
23	**Social Worker**						
24	**X-ray Tech**						
25	**Other 1**						
26	**Other 2**						
27							
28	**TOTAL**	0	0	0	0	0	0

AMERICAN OVERSIGHT

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2	**1 FTE = 40 hours / per week*
3	
4	**Comments**
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AMERICAN OVERSIGHT

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3	**INTRODUCTION TO THE QMC**
4	These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc. Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.
5	• These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
6	• The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
7	• The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.
8	• The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody ≥ 14 days.
9	• In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
10	• While the goal is 100% compliance, the performance objective for most of the audit tools is ≥ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
11	• The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
12	• In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.
13	
14	**AUDIT TOOL COMPLETION**
15	Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer. Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.
16	
17	**TIPS FOR REVIEWERS**
18	• Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

AMERICAN OVERSIGHT

	A
19	• Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.
20	• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
21	• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
22	• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
23	• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
24	• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
25	• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
26	• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
27	• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

	A	B	C
1	**Term**	**Description**	
2	A#	Enter A# in format 123456789. Omit all leading characters such as "A".	
3	N/A - LOS	N/A Due to Length of Stay	
4	N/A - NLOS	N/A Not Due to Length of Stay	
5	ASM	Asthma	
6	CG	Complaints and Grievance	
7	CM	Continuity of Medications	
8	DC	Dental Care	
9	DM	Diabetes	
10	DSA	Diagnostic Services and Specialty Care Access	
11	EED	Evaluation of Care Prior to Emergency Department	
12	HA	Health Assessment	
13	HIV	Human Immunodeficiency Virus	
14	HTN	Hypertension	
15	LT	Laboratory Testing	
16	MR	Medical Recordkeeping	
17	MAR	Medication Administration Records	
18	MHS	Mental Health Screen	
19	MHT	Mental Health Treatment Planning	
20	PG	Pregnant Women	
21	SZ	Seizure Disorder	
22	SS	Suicide Screening	
23	TD	Treatment of Disability	
24	UC	Urgent Care (Sick Call)	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**ASTHMA (MODERATE AND SEVERE)**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		8						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs (Medical Administrative Record).							
6	**Sample:**	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
7		NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Guidelines:**	National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3.							
10		https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf							
11		Peak Expiratory Flow Rates, (Sept, 2016)							
12		http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
13	**Remarks:**	b(6), b(7)(c)-part of assessment documentation missing on MD's HP; b(6), b(7)(c)-labs ordered and drawn a month later							
14	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/18/2019		
15									
16				**Facility (f)**					
17	**fASM-1a:**	Does the facility follow a particular clinical practice guideline to manage asthma?						N	
18	**~~fASM-1b:~~**	~~If yes, what is the guideline?~~			~~BOP Clinical Practice Guidelines~~				
19									
20									
21				**Clinical (c)**					
22	**cASM-1**	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cASM-2**	Was a peak flow completed at the initial physical exam?							
24	**cASM-3**	Was a peak flow completed at the CC visit or within the last 3 months?							
25	**cASM-4**	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
26									
27	**Totals:**		8	8	8	7			
28	**Total Applicable:**		8	8	8	8			
29	**Total Met:**		8	8	8	7			
30	**% Compliance:**	97%	100%	100%	100%	88%			
31				**A#**					
32	**Patient(s)**	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
33	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
34	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
35	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
36	4	b(6), b(7)(c)	Yes	Yes	Yes	No			
37	5	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
38	6	b(6), b(7)(c)	Yes	Yes	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
39	7	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
40	8	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
41	9		Select	Select	Select	Select			
42	10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1					**DIABETES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		3						
3					10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with diabetes chosen at random, if available.							
7	**~~Guidelines:~~**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Remarks:**	213475359-seen by MD on day 8; pt has unstable blood sugars. MD planned to f/u unstable case in 60 days. 203563756-labs ordered and received 5 labs and requested f/u in 90 days; HgA1C not ordered on CC visit 13 days after admission; ordered almost 2 months later. BS flowsheet in chart for present at facility over 7 months. Seen for HP on day 11. 201526641-labs done a month after arrival							
10	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		12/19/2019	
11									
12					**Facility (f)**				
13	**~~fDM-1:~~**	What clinical practice guideline does the							
14		facility use to manage diabetes?					~~BOP Clinical Practice Guideline~~		
15									
16					**Clinical (c)**				
17	**cDM-1**	Was blood sugar measured and recorded on intake?							
18	**cDM-2**	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable pa medications (4 or more) should be seen sooner.)							
19	**cDM-3**	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?							
20	**cDM-4**	Were lipids measured within one year?							
21	**cDM-5**	Was patient followed at least every 90 days with appropriate vital signs?							
22	**cDM-6**	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.							
23	**cDM-7**	Was degree of control (goal HgbA1C <8.0) documented?							
24	**cDM-8**	Was a strategy to attain diabetes control documented if HgbA1C was above goal?							
25									
26	**Total Applicable:**		3	3	3	3	3	0	3
27	**Total Met:**		3	2	2	3	2	0	2
28	**% Compliance:**	76%	100%	67%	67%	100%	67%		67%
29					**0**				
30	**Patient(s)**	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**
31	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	N/A - NLOS	No
32	2	b(6), b(7)(c)	Yes	Yes	No	Yes	No	N/A - NLOS	Yes
33	3	b(6), b(7)(c)	Yes	No	Yes	Yes	Yes	N/A - NLOS	Yes
34	4		Select	Select	Select	Select	Select	Select	Select
35	5		Select	Select	Select	Select	Select	Select	Select
36	6		Select	Select	Select	Select	Select	Select	Select
37	7		Select	Select	Select	Select	Select	Select	Select
38	8		Select	Select	Select	Select	Select	Select	Select
39	9		Select	Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	J	K
1		
2		
3		
4		
5		
6		
7		
8		
9	days later, MD was pending 7 days only; detainee was	
10		
11		
12		
13		
14		
15		
16		
17		
18	atients or those on multiple	
19		
20		
21		
22		
23		
24		
25		
26	3	
27	2	
28	67%	
29		
30	**cDM-8**	
31	No	
32	Yes	
33	Yes	
34	Select	
35	Select	
36	Select	
37	Select	
38	Select	
39	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
40	10		Select	Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	J	K
40	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HIV**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		2						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
6	**Sample:**	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
7		National Institutes of Health. Aids Info.		https://aidsinfo.nih.gov/guidelines			http://nccc.ucsf.edu		
8	**Guidelines:**	University of California, San Francisco. HIV Clinical Consultation Center.							
9		ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
10	**Remarks:**	203564061-planted a TB skin test vs chest x-ray, no labs ordered during chronic tx plan documentation (initial tx plan f/u for 90 days) or H/P, no documentation of referral to specialist, detainee went to sick call x 3 for respiratory infection, sore throat rash w/no labs ordered before going to ER; no MedPAR noted on chart, no chest x-ray; labs done almost 2 months after admission; 203462973-detainee disclosed HIV status after 6 months after being detaineed for fear of deportation, no referral to specialist, detainee referred to health dept when chained out, labs were ordered on day that was reported and not done until 10 days later when seen on chronic care visit and sent out to ER, no chest x-ray ordered when status disclosed							
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019		
12									
13				**Facility (f)**					
14	**~~fHIV-1:~~**	What clinical practice guideline does the facility			~~BOP Clinical Practice Guidelines~~				
15		use to manage HIV?							
16									
17				**Clinical (c)**					
18	**cHIV-1**	How was HIV status identified? By laboratory, prior medical records or patient report?							
19	**cHIV-2**	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
20	**cHIV-3**	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
21	**cHIV-4**	Was antiretroviral treatment considered and documented?							
22	**cHIV-5**	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
23	**cHIV-6**	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
24									
25	**Total Applicable:**			2	2	2	2	2	
26	**Total Met:**			0	0	2	2	0	
27	**% Compliance:**	40%		0%	0%	100%	100%	0%	
28									
29	**Patient(s)**	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
30	1	b(6), b(7)(c)	Patient Interview	No	No	Yes	Yes	No	
31	2	b(6), b(7)(c)	Patient Interview	No	No	Yes	Yes	No	
32	3		Select	Select	Select	Select	Select	Select	
33	4		Select	Select	Select	Select	Select	Select	
34	5		Select	Select	Select	Select	Select	Select	
35	6		Select	Select	Select	Select	Select	Select	
36	7		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
37	8		Select	Select	Select	Select	Select	Select	
38	9		Select	Select	Select	Select	Select	Select	
39	10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HYPERTENSION**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with hypertension chosen at random, if available.							
7	**Guidelines:**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Remarks:**	b(6), b(7)(c)-172/98 noted on 11/11, detainee seen 14 days later by MD. During that timeframe, couldn't tell if Lisinopril was ordered before chronic care visit. But, B/P checks ordered 5 days later when returned from inpatient visit. No evidence that other HTN Clinical Practice Guidelines were followed (no EKG, labs, etc.)b(6), b(7)(c)-BP checks done; seen on day 13 for chronic care and f/u for 60 days, labs ordered and not done, no EKG b(6), b(7)(c)-labs done 5 days after ordered; no BP flowsheet, BP missing on intake. b(6), b(7)(c)-CC visit 3 months after intake, EKG over 3 months b(6), b(7)(c)-labs ordered twice not done, CC f/u for 180 days b(6), b(7)(c)-labs & EKG a month after order, no BP checksb(6), b(7)(c) no labs, EKG, BP checks							
10									
11									
12	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019		
13									
14				**Facility (f)**					
15	**fHTN-1a:**	Does the facility follow a clinical practice guideline to manage hypertension?						Y	
16	**fHTN-1b:**	If yes, what is the guideline?			BOP Clinical Practice Guidelines				
17									
18									
19				**Clinical (c)**					
20	**cHTN-1**	Was a blood pressure reading noted at intake?							
21	**cHTN-2**	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
22	**cHTN-3**	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cHTN-4**	Was a chronic disease guideline, including baseline laboratory testing, followed?							
24									
25	**Total Applicable:**		10	10	10	10			
26	**Total Met:**		9	7	7	2			
27	**% Compliance:**	63%	90%	70%	70%	20%			
28									
29	**Patient(s)**	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
30	1	b(6), b(7)(c)	Y	No	No	No			
31	2	b(6), b(7)(c)	Y	Yes	Yes	No			
32	3	b(6), b(7)(c)	N	Yes	Yes	No			
33	4	b(6), b(7)(c)	Y	No	No	No			
34	5	b(6), b(7)(c)	Y	Yes	Yes	No			
35	6	b(6), b(7)(c)	Y	Yes	Yes	No			
36	7	b(6), b(7)(c)	Y	Yes	Yes	No			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
37	8	b(6), b(7)(c)	Y	Yes	Yes	Yes			
38	9	b(6), b(7)(c)	Y	Yes	Yes	Yes			
39	10	b(6), b(7)(c)	Y	No	No	No			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**SEIZURE DISORDER**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** (please select 0 if no files/patients reviewed)		4					
3				10				
4	**Purpose:**	To prevent deterioration in function and cost of unnecessary care.						
5	**Source:**	Chronic disease registry or MARs.						
6	**Sample:**	10 patients with seizure disorder chosen at random, if available.						
7	**Guidelines:**							
8	**Remarks:**	b(6), b(7)(c)-no order for bottom bunk on initial intake form. Nurse noted last known seizure & med. Detainee had a seizure 4 days after arrival, meds increased, seen 6 days later for chronic care visit & 8 days later for H/P. provider noted f/u for 60 days. b(6), b(7)(c)-nurse noted the last seizure, provider note f/u for 180 days & he ordered meds & didn't have labs. Detainee seen on day 6. BP 158/102 on CC visit, not addressed & MD wrote BP is "normal for his country".b(6), b(7)(c)-MD saw detainee after his return						
9		from ER visit over a month after admission to facility. Labs were ordered on intake and not done. Treatment plan established after						
10		ER/hospital admission for Dilantin toxicity which was 24 days after arrival						
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019	
12								
13			**Facility (f)**					
14	**~~fSZ-1:~~**	What clinical practice guideline does the facility			~~BOP Clinical Practice Guidelines~~			
15		use to manage seizures?						
16								
17			**Clinical (c)**					
18	**cSZ-1**	Was an appropriate neurological history completed at the initial physical examination?						
19	**cSZ-2**	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.						
20	**cSZ-3**	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?						
21	**cSZ-4**	Was a treatment plan established?						
22	**cSZ-5**	Are there orders for a bottom bunk?						
23								
24	**Total Applicable:**		4	4	4	4	4	
25	**Total Met:**		1	2	1	3	2	
26	**% Compliance:**	45%	25%	50%	25%	75%	50%	
27								
28	**Patient(s)**	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**	
29	1	b(6), b(7)(c)	No	No	No	Yes	No	
30	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
31	3	b(6), b(7)(c)	No	Yes	No	Yes	Yes	
32	4	b(6), b(7)(c)	No	No	No	No	No	
33	5		Select	Select	Select	Select	Select	
34	6		Select	Select	Select	Select	Select	
35	7		Select	Select	Select	Select	Select	
36	8		Select	Select	Select	Select	Select	
37	9		Select	Select	Select	Select	Select	

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	A	B	C	D	E	F	G	H
38	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1			**CONTINUITY OF MEDICATIONS**						
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess timeliness of medication, as ordered.							
5	**Source:**	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).							
6	**Sample:**	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.							
7	**Guidelines:**								
8									
9	**Remarks:**	~~b(6), b(7)(c) and b(6), b(7)(c)-meds received within 48 hours; b(6), b(7)(c)-nurse did note attempt to contact pharmacy and notes of when HIV meds would be available; b(6), b(7)(c)-detainee arrived on 7/23 and MAR on chart of August only~~							
10									
11	**Reviewer:**	b(6), b(7)©			**Date Reviewed:**		12/19/2019		
12									
13				**Clinical (c)**					
14	**cCM-1**	Period of time from completion of intake screening to the ordering of medications less than 24 hours?							
15	**cCM-2**	Period of time from order to first dose less than 24 hours?							
16									
17	**Total Applicable:**		10	10					
18	**Total Met:**		10	6					
19	**% Compliance:**	80%	100%	60%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cCM-1**	**cCM-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	No					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	No					
26	5	b(6), b(7)(c)	Yes	No					
27	6	b(6), b(7)(c)	Yes	Yes					
28	7	b(6), b(7)(c)	Yes	Yes					
29	8	b(6), b(7)(c)	Yes	No					
30	9	b(6), b(7)(c)	Yes	Yes					
31	10	b(6), b(7)(c)	Yes	Yes					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**DENTAL CARE**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess compliance with detention standards and continuity of care.							
5	**Source:**	Dental sick call list or dental referral log.							
6	**Sample:**	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)©			**Date Reviewed:**		12/20/2019		
12									
13				**Clinical (c)**					
14	**cDC-1**	Was patient screened for symptoms during the intake process?							
15	**cDC-2**	Was patient evaluated by a qualified health professional within 48 hours of request?							
16	**cDC-3**	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
17	**cDC-4**	Was the patient scheduled for follow-up treatment as recommended?							
18									
19	**Total Applicable:**		10	10	10	7			
20	**Total Met:**		10	10	10	7			
21	**% Compliance:**	100%	100%	100%	100%	100%			
22									
23	**Patient(s)**	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
24	1	b(6), b(7)(c)	Y	Yes	Yes	Yes			
25	2	b(6), b(7)(c)	Y	Yes	Yes	Yes			
26	3	b(6), b(7)(c)	Y	Yes	Yes	Yes			
27	4	b(6), b(7)(c)	Y	Yes	Yes	Yes			
28	5	b(6), b(7)(c)	Y	Yes	Yes	Yes			
29	6	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
30	7	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
31	8	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
32	9	b(6), b(7)(c)	Y	Yes	Yes	Yes			
33	10	b(6), b(7)(c)	Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		4					
3				10				
4	**Purpose:**	To assess timeliness of off-site diagnostic services and specialty care.						
5	**Source:**	Referrals log, medical records or MedPars.						
6	**Sample:**	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
7	**Guidelines:**	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
8		b(6), b(7)(c)-CT Scan ordered entered in MedPAR 13 days after request. b(6), b(7)(c)-Provider acknowledged x-ray report, but no						
9	**Remarks:**	date and time. 213294447-EKG ordered. Not done when chained out 3 days later; b(6), b(7)(c)-MedPAR entered a month after order						
10				for sonogram of testicles				
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019	
12								
13			**Clinical (c)**					
14	**cDSA-1**	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
15	**cDSA-2**	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., “return in 90 days”?						
16	**cDSA-3**	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
17	**cDSA-4**	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
18								
19	**Total Applicable:**			4	3	3	3	
20	**Total Met:**			1	2	3	2	
21	**% Compliance:**	65%		25%	67%	100%	67%	
22								
23	**Patient(s)**	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
24	1	b(6), b(7)(c)	Other	No	Yes	Yes	Yes	
25	2	b(6), b(7)(c)	Other	Yes	Yes	Yes	No	
26	3	b(6), b(7)(c)	Other	No	N/A - LOS	N/A - LOS	N/A - LOS	
27	4	b(6), b(7)(c)	Other	No	No	Yes	Yes	
28	5		Select	Select	Select	Select	Select	
29	6		Select	Select	Select	Select	Select	
30	7		Select	Select	Select	Select	Select	
31	8		Select	Select	Select	Select	Select	
32	9		Select	Select	Select	Select	Select	
33	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		5					
3				10				
4	**Purpose:**	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbou						
5	**Source:**	Emergency Department (ED) logs.						
6	**Sample:**	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, sk tissue infections, DKA, abdominal pain, or chest pain.						
7	**Guidelines:**	NCCHC 2014 J-E-12.						
8	**Remarks:**	b(6), b(7)(c)-Labs were not drawn after intake per telephone order. Labs drawn after ordered a second time during chronic care visit 8 days later. Intake BS h btw. b(6), b(7)(c) before chronic care visit and insulin was d/c and rx Metformin only. b(6), b(7)(c)-no labs drawn upon arrival or when detainee presented to						
9		3 before being sent to ER b(6), b(7)(c)-once detainee disclosed HIV status 6 months later, detainee was not seen by MD until 10 days later and labs were not						
10		ordered on the date of disclosure; b(6), b(7)(c)-provider did not see detainee for chronic care visit, meds and Dilantin levels were ordered and not do						
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		12/19/20
12								
13			**Clinical (c)**					
14	**cEED-1**	Is there an outbound progress note?						
15	**cEED-2**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the repor						
16	**cEED-3**	Is there discharge documentation from the hospital or ED in the chart?						
17	**cEED-4**	Is there an inbound assessment?						
18	**cEED-5**	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?						
19								
20	**Total Applicable:**			5	5	5	5	5
21	**Total Met:**			5	1	5	4	4
22	**% Compliance:**	76%		100%	20%	100%	80%	80%
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
25	1	b(6), b(7)(c)	High blood sugar; reported weakness	Yes	Yes	Yes	Yes	No
26	2	b(6), b(7)(c)	HIV pt-coughing, tachycardia, febrile, rash	Yes	Yes	Yes	No	Yes
27	3	b(6), b(7)(c)	HIV-r/o coccidycosis and AIDs	Yes	Yes	Yes	Yes	Yes
28	4	b(6), b(7)(c)	Dilantin toxicity	Yes	Yes	Yes	Yes	Yes
29	5	b(6), b(7)(c)	cellulitis of elbow	Yes	No	Yes	Yes	Yes
30	6			Select	Select	Select	Select	Select
31	7			Select	Select	Select	Select	Select
32	8			Select	Select	Select	Select	Select
33	9			Select	Select	Select	Select	Select
34	10			Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**COMPLAINTS AND GRIEVANCES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		3					
3				10				
4	**Purpose:**	To assess use of medical grievance data as part of the quality management program.						
5	**Source:**	Facility grievance logs.						
6	**Sample:**	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
7	**Guidelines:**	NCCHC 2014 J-A-06, J-A-11.						
8								
9	**Remarks:**	~~Detainee c/o hurting, but no sick call request. Seen the same day of grievance review. The other detainee wanted to know when he was going to see sick call and another wanted information about surgery date.~~						
10								
11	**Reviewer:**	Type Text Here			**Date Reviewed:**		Select	
12								
13				**Facility (f)**				
14	**~~fCG-1:~~**	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care?						N
15		If yes, please address in the remarks section whether and how the facility uses this information to implement change.						
16	**fCG-2:**	How many medical grievances were submitted over the past 3 months?				3		
17	**fCG-3:**	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?				3		
18								
19				**Clinical (c)**				
20	**cCG-1**	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
21	**cCG-2**	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
22								
23	**Totals:**	3	0	0	3	0	0	0
24								
25	**Patient(s)**	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
26	1	b(6), b(7)(c)	0	0	1	0	0	0
27	2	b(6), b(7)(c)	0	0	1	0	0	0
28	3	b(6), b(7)(c)	0	0	1	0	0	0
29	4		Select	Select	Select	Select	Select	Select
30	5		Select	Select	Select	Select	Select	Select
31	6		Select	Select	Select	Select	Select	Select
32	7		Select	Select	Select	Select	Select	Select
33	8		Select	Select	Select	Select	Select	Select
34	9		Select	Select	Select	Select	Select	Select
35	10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**HEALTH ASSESSMENT**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		20					
3				20				
4	**Purpose:**	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.						
5	**Source:**	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.						
6	**Sample:**	20 medical records chosen at random.						
7	**Guidelines:**	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25						
8	**Remarks:**	b(6),b(7)(c)-uncontrolled DM patient seen on day 8; b(6),b(7)(c)-HIV pt tx plan documented 5 days later & H/P 12 days later by RN instead of providers;b(6),b(7)(c)once HIV dx was made no chest x-ray wasordered,detainee saw mental health 20 days after referred;b(6),b(7)(c)-dates noted under seizure tab; b(6), b(7)(c)-chronic care appt on day7 & H/P on day9;b(6), b(7)(c)-detainee seen on day8 for H/P & MD ordered labs&meds on chronic care visit, but f/u for180 days in chronic care clinic;b(6), b(7)(c)-seen for H/P day7, meds&seizure hx not obtained until detainee was admitted for Dilantin toxicity over 20 days after arrival.Detainee had been seen on sick call several times and treated for diarrhea and other s/s.Dilantin levels not drawn						
9								
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019	
12								
13			**Clinical (c)**					
14	**cHA-1**	Initial screen complete within 12 hours of booking?						
15	**cHA-2**	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?						
16	**cHA-3**	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?						
17	**cHA-4**	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.						
18	**cHA-5**	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.						
19				**0**				
20	**Total Applicable:**		20	20	7	20	20	
21	**Total Met:**		20	18	6	14	13	
22	**% Compliance:**	82%	100%	90%	86%	70%	65%	
23								
24	**Patient(s)**	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**	
25	1	b(6), b(7)(c)	Yes	Yes	N/A	No	No	
26	2	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
27	3	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
28	4	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
29	5	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
30	6	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
31	7	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	
32	8	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
33	9	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
34	10	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
35	11	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	

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	A	B	C	D	E	F	G	H
36	12	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
37	13	b(6), b(7)(c)	Yes	No	Yes	No	No	
38	14	b(6), b(7)(c)	Yes	No	No	No	Yes	
39	15	b(6), b(7)(c)	Yes	Yes	N/A	No	No	
40	16	b(6), b(7)(c)	Yes	Yes	N/A	Yes	No	
41	17	b(6), b(7)(c)	Yes	Yes	N/A	No	No	
42	18	b(6), b(7)(c)	Yes	Yes	N/A	No	No	
43	19	b(6), b(7)(c)	Yes	Yes	N/A	Yes	No	
44	20	b(6), b(7)(c)	Yes	Yes	N/A	Yes	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**LABORATORY TESTING**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To assess timeliness, continuity, and coordination of care.						
5	**Source:**	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
6	**Sample:**	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
7	**Guidelines:**							
8	**Remarks:**	b(6), b(7)(c)-labs weren't drawn upon intake. Drawn when ordered a second time, but BS 487 and insulin was d/c. Nurse noted where detainee asked a question about why he didn't receive Insulin. b(6), b(7)(c)-labs drawn 8 and 13 days after ordered. No notes showing where provider addressed high cholestrol levels after labs returned and update problem list b(6), b(7)(c)-labs done almost 2 months after admission, no notes or referral to specialist; b(6), b(7)(c)-labs obtained 9 days after ordered on HIV detainee who was over 6 months without meds d/t not reporting; b(6), b(7)(c)-dilantin levels no completed; provider ordered labs on zika, MMR, etc were done in a timely manner. b(6), b(7)(c)-dilantin levels ordered and not completed						
9								
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/19/2019	
12								
13			**Clinical (c)**					
14	**cLT-1**	Was blood drawn or test done within 1 business day of ordered date?						
15	**cLT-2**	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
16	**cLT-3**	Was there clinical acknowledgment?						
17	**cLT-4**	Was there an appropriate clinical response?						
18	**cLT-5**	Was patient advised of laboratory results?						
19								
20	**Total Applicable:**		10	9	8	8	7	
21	**Total Met:**		3	7	6	3	0	
22	**% Compliance:**	44%	30%	78%	75%	38%	0%	
23								
24	**Patient(s)**	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
25	1	b(6), b(7)(c)	No	N/A	N/A	N/A - NLOS	N/A - NLOS	
26	2	b(6), b(7)(c)	Yes	Yes	Yes	No	No	
27	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes	No	
28	4	b(6), b(7)(c)	Yes	Yes	Yes	Yes	N/A - NLOS	
29	5	b(6), b(7)(c)	No	Yes	Yes	Yes	No	
30	6	b(6), b(7)(c)	No	Yes	Yes	No	No	
31	7	b(6), b(7)(c)	No	Yes	No	No	No	
32	8	b(6), b(7)(c)	No	Yes	Yes	No	No	
33	9	b(6), b(7)(c)	No	No	No	No	No	
34	10	b(6), b(7)(c)	No	No	N/A	N/A - LOS	N/A - LOS	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**MEDICATION ADMINISTRATION RECORDS**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
5	**Source:**	MARS.							
6	**Sample:**	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
7	**Guidelines:**								
8									
9	**Remarks:**	b(6), b(7)(c)-two MAR blanks on the same date. One missing MAR noted during the review.							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/20/2019		
12									
13				**Facility (f)**					
14	**fMAR-1:**	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?						Y	
15	**fMAR-2:**	Based on review of current month MARs or previous month's MARs, if available, what						5	
16		percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?							
17	**fMAR-3:**	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?						0	
18	**fMAR-4:**	Estimate the percentage of patients on self-administered medication ordered by a provider.						80	
19	**fMAR-5:**	OTCs provided by medical, commissary or both?						Both	
20									
21				**Clinical (c)**					
22	**cMAR-1**	What is the number of refusals and no shows during the previous month for each patient?							
23	**cMAR-2**	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
24	**cMAR-3**	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
25									
26	**Total Applicable:**			1	0				
27	**Total Met:**			0	0				
28	**% Compliance:**	0%		0%					
29									
30	**Patient(s)**	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
31	1	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
32	2	b(6), b(7)(c)	2	No	N/A - NLOS				
33	3	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
34	4	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
35	5	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
36	6	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
37	7	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
38	8	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
39	9	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
40	10	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**MEDICAL RECORD-KEEPING PRACTICES**			
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10				
3							
4	**Purpose:**	To assess completeness of the medical record and appropriateness of medical record practices.					
5	**Source:**	Medical Records, Chronic Care Log, and MARs.					
6	**Sample:**	10 records of detainees with chronic disease, if available.					
7	**Instructions:**	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For exa progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."					
8	**Guidelines:**	NCCHC 2014 J-H-01, J-H-03.					
9							
10	**Remarks:**			MedPARs aren't consistenly placed in chart			
11							
12	**Reviewer:**		b(6), b(7)(c)		**Date Reviewed:**	12/20/2019	
13							
14				**Facility (f)**			
15	**fMR-1:**	Type of Medical Records?		Paper			
16	**~~fMR-2:~~**	~~Name of Electronic Health Record?~~				~~N/A~~	
17							
18							
19	**Total Applicable:**		10	10	10	10	10
20	**Total Met:**		10	9	10	10	10
21	**% Compliance:**	99%	100%	90%	100%	100%	100%
22							
23	**Patient(s)**	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments; known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**
24	1	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
25	2	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
26	3	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
27	4	b(6), b(7)(c)	Compliant	Non-Compliant	Compliant	Compliant	Compliant
28	5	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
29	6	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
30	7	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
31	8	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
32	9	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
33	10	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

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16	
17	
18	
19	7
20	7
21	100%
22	
23	**MARs:** Placed in record within 2 weeks of previous month
24	Compliant
25	N/A
26	Compliant
27	Compliant
28	N/A
29	N/A
30	Compliant
31	Compliant
32	Compliant
33	Compliant

AMERICAN OVERSIGHT

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19	6	3	10	5	7	9	4	5
20	6	3	10	5	7	9	4	5
21	100%	100%	100%	100%	100%	100%	100%	100%
22								
23	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**
24	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A
25	Compliant	N/A	Compliant	N/A	N/A	N/A	N/A	Compliant
26	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	N/A
27	Compliant	N/A	Compliant	N/A	Compliant	Compliant	Compliant	Compliant
28	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant
29	Compliant	N/A	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
30	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant
31	N/A	N/A	Compliant	N/A	Compliant	Compliant	N/A	N/A
32	N/A	N/A	Compliant	Compliant	N/A	Compliant	N/A	N/A
33	N/A	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A

AMERICAN OVERSIGHT

	Q	R	S	T	U	V	W
1							
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18							
19	10	10	10	10	10	0	0
20	10	10	10	10	10	0	0
21	100%	100%	100%	100%	100%		
22							
23	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
24	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
25	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
26	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
27	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
28	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
29	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
30	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
31	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
32	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
33	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**MENTAL HEALTH SCREEN**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		7						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
5	**Source:**	Intake screens of detainees, mental health referral logs, mental health caseload.							
6	**Sample:**	10 randomly selected intake screens with positive mental health screens, if available.							
7	**Guidelines:**								
8									
9	**Remarks:**			Type Text Here					
10									
11	**Reviewer:**	b(6), b(7)©			**Date Reviewed:**		12/20/2019		
12									
13				**Clinical (c)**					
14	**cMHS-1**	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
15									
16	**Total Applicable:**		7						
17	**Total Met:**		7						
18	**% Compliance:**	100%	100%						
19									
20	**Patient(s)**	**A# (numbers only)**	**cMHS-1**						
21	1	b(6), b(7)(c)	Yes						
22	2	b(6), b(7)(c)	Yes						
23	3	b(6), b(7)(c)	Yes						
24	4	b(6), b(7)(c)	Yes						
25	5	b(6), b(7)(c)	Yes						
26	6	b(6), b(7)(c)	Yes						
27	7	b(6), b(7)(c)	Yes						
28	8		Select						
29	9		Select						
30	10		Select						

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				MENTAL HEALTH TREATMENT PLANNING					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		7						
3				10					
4	**Purpose:**	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).							
5	**Source:**	Patients on mental health caseload, including all patients on psychotropic medication.							
6	**Sample:**	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.							
7	**Guidelines:**	NCCHC 2014 J-G-04 (Item 2)							
8									
9	**Remarks:**	b(6), b(7)(c)-detainee seen 20 days after referral to mental health (per staff, normal time is 72 hours)							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/18/2019		
12									
13				**Clinical (c)**					
14	**cMHT-1**	Is a clinical assessment, treatment, and follow-up plan documented?							
15	**cMHT-2**	Are treatment plans updated at a minimum of every 90 days?							
16									
17	**Total Applicable:**		7	7					
18	**Total Met:**		7	6					
19	**% Compliance:**	93%	100%	86%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cMHT-1**	**cMHT-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	Yes					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	Yes					
26	5	b(6), b(7)(c)	Yes	No					
27	6	b(6), b(7)(c)	Yes	Yes					
28	7	b(6), b(7)(c)	Yes	Yes					
29	8		Select	Select					
30	9		Select	Select					
31	10		Select	Select					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**PREGNANT WOMEN**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To determine compliance with detention standards and continuity and coordination of care.						
5	**Source:**	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
6	**Sample:**	10 pregnant detainees, if available.						
7	**Guidelines:**	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		Select	
12								
13				**Facility (f)**				
14	**fPG-1:**	Does the facility perform a pregnancy test on females aged 10 to 56 during				Select		
15		intake screening?						
16								
17				**Clinical (c)**				
18	**cPG-1**	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
19	**cPG-2**	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
20	**cPG-3**	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
21	**cPG-4**	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
22	**cPG-5**	Were prenatal vitamins prescribed?						
23								
24	**Total Applicable:**		0	0	0	0	0	
25	**Total Met:**		0	0	0	0	0	
26	**% Compliance:**							
27								
28	**Patient(s)**	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
29	1		Select	Select	Select	Select	Select	
30	2		Select	Select	Select	Select	Select	
31	3		Select	Select	Select	Select	Select	
32	4		Select	Select	Select	Select	Select	
33	5		Select	Select	Select	Select	Select	
34	6		Select	Select	Select	Select	Select	
35	7		Select	Select	Select	Select	Select	
36	8		Select	Select	Select	Select	Select	
37	9		Select	Select	Select	Select	Select	
38	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**SUICIDE SCREENING**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.						
5	**Source:**	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
6	**Sample:**	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
7	**Guidelines:**	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	Type Text Here			**Date Reviewed:**		Select	
12								
13				**Facility (f)**				
14	**fSS-1:**	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?					Select	
15	**fSS-2:**	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?					Select	
16	**fSS-3:**	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?					Select	
17								
18				**Clinical (c)**				
19	**cSS-1**	What type of monitoring was practiced while the patient was on suicide watch?						
20	**cSS-2**	Were checks documented consistently?						
21	**cSS-3**	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?						
22	**cSS-4**	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?						
23	**cSS-5**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.						
24								
25	**Total Applicable:**			0	0	0	0	
26	**Total Met:**			0	0	0	0	
27	**% Compliance:**							
28								
29	**Patient(s)**	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**	
30	1		Select	Select	Select	Select	Select	
31	2		Select	Select	Select	Select	Select	
32	3		Select	Select	Select	Select	Select	
33	4		Select	Select	Select	Select	Select	
34	5		Select	Select	Select	Select	Select	
35	6		Select	Select	Select	Select	Select	
36	7		Select	Select	Select	Select	Select	
37	8		Select	Select	Select	Select	Select	
38	9		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
39	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**TREATMENT OF DISABILITY**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		3					
3				10				
4	**Purpose:**	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment. See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf						
5	**Source:**	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
6	**Sample:**	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
7	**Guidelines:**	NCCHC J-G-02.						
8								
9	**Remarks:**	b(6), b(7)(c)-detainee was on crutches. Sticker notification on chart, but not on problem list.						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		12/18/2019	
12								
13			**Facility (f)**					
14	**fTD-1:**	Does the facility maintain a current list of all patients with disabilities on site?					Y	
15								
16			**Clinical (c)**					
17	**cTD-1**	Is the disability prominently noted in the file, along with any needed accommodations?						
18	**cTD-2**	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
19	**cTD-3**	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
20	**cTD-4**	Was ADL assistance provided, if applicable?						
21								
22	**Total Applicable:**		3	3	3	0		
23	**Total Met:**		3	3	3	0		
24	**% Compliance:**	100%	100%	100%	100%			
25								
26	**Patient(s)**	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
27	1	b(6), b(7)(c)	Yes	Yes	Yes	N/A - NLOS		
28	2	b(6), b(7)(c)	Yes	Yes	Yes	N/A - NLOS		
29	3	b(6), b(7)(c)	Yes	Yes	Yes	N/A - NLOS		
30	4		Select	Select	Select	Select		
31	5		Select	Select	Select	Select		
32	6		Select	Select	Select	Select		
33	7		Select	Select	Select	Select		
34	8		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
35	9		Select	Select	Select	Select		
36	10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**URGENT CARE (SICK CALL)**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		Select	Add Sample Rows		Reset Sample Rows		
3				10				
4	**Purpose:**	To assess for timely and appropriate nursing care for acute conditions.						
5	**Source:**	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
6	**Sample:**	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious con include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
8								
9	**Remarks:**	~~b(6), b(7)(c)-nursing note showing report of HTN history, 4 day BP check with high blood pressures completed and note to f/u with provider, but no documen~~ showed that the detainee was seen						
10								
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		12/18/20
12								
13				**Clinical (c)**				
14	**cUC-1**	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
15	**cUC-2**	Was care delivered within the scope of the nurse's license?						
16	**cUC-3**	Were vital signs documented during the nurse's assessment?						
17	**cUC-4**	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
18	**cUC-5**	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
19								
20	**Total Applicable:**			10	10	10	10	6
21	**Total Met:**			10	10	10	9	5
22	**% Compliance:**	95%		100%	100%	100%	90%	83%
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
25	1	b(6), b(7)(c)	respiratory infection	Yes	Yes	Yes	Yes	Yes
26	2	b(6), b(7)(c)	dental cavity	Yes	Yes	Yes	Yes	Yes
27	3	b(6), b(7)(c)	sore throat	Yes	Yes	Yes	Yes	N/A - NLOS
28	4	b(6), b(7)(c)	athletes foot	Yes	Yes	Yes	Yes	Yes
29	5	b(6), b(7)(c)	dental pain	Yes	Yes	Yes	Yes	Yes
30	6	b(6), b(7)(c)	sore throat	Yes	Yes	Yes	Yes	N/A - NLOS
31	7	b(6), b(7)(c)	tooth pain	Yes	Yes	Yes	Yes	Yes
32	8	b(6), b(7)(c)	HTN	Yes	Yes	Yes	No	No
33	9	b(6), b(7)(c)	abdominal pain	Yes	Yes	Yes	Yes	N/A - NLOS
34	10	b(6), b(7)(c)	diarrhea	Yes	Yes	Yes	Yes	N/A - NLOS

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1											
2			**Dates**	**States**							
3	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select
4	Yes	Yes	1/1/2019	AL	Recent Lab	Y	Cardiology	Medical	Paper	Compliant	Constant (1:1)
5	No	No	1/2/2019	AK	Patient Interview	N	Endocrinology	Commissary	Electronic	Partial Compliance	Constant (camera)
6	N/A	N/A - LOS	1/3/2019	AZ	Medical Record		Gastroenterology	Both	Both	Non-Compliant	At least q 15 min
7		N/A - NLOS	1/4/2019	AR			General Surgery			N/A	Less often
8			1/5/2019	CA			Hematology				
9			1/6/2019	CO			Infectious Disease				
10			1/7/2019	CT			Neurology				
11			1/8/2019	DE			OB/Gyn				
12			1/9/2019	FL			Oncology				
13			1/10/2019	GA			Opthalmology				
14			1/11/2019	HI			Orthopedics				
15			1/12/2019	ID			Psychiatry				
16			1/13/2019	IL			Pulmonology				
17			1/14/2019	IN			Rheumatology				
18			1/15/2019	IA			Other				
19			1/16/2019	KS							
20			1/17/2019	KY							
21			1/18/2019	LA							
22			1/19/2019	ME							
23			1/20/2019	MD							
24			1/21/2019	MA							
25			1/22/2019	MI							
26			1/23/2019	MN							
27			1/24/2019	MS							
28			1/25/2019	MO							
29			1/26/2019	MT							
30			1/27/2019	NE							
31			1/28/2019	NV							
32			1/29/2019	NH							
33			1/30/2019	NJ							
34			1/31/2019	NM							
35			2/1/2019	NY							
36			2/2/2019	NC							
37			2/3/2019	ND							
38			2/4/2019	OH							
39			2/5/2019	OK							
40			2/6/2019	OR							
41			2/7/2019	PA							
42			2/8/2019	RI							
43			2/9/2019	SC							
44			2/10/2019	SD							
45			2/11/2019	TN							
46			2/12/2019	TX							

AMERICAN OVERSIGHT

	L	M	N
1			
2		**Organization**	**AOR**
3	Select	Select	Select
4	0	IHSC	ATL
5	1	Other	BAL
6	2		BOS
7	3		BUF
8	4		CHI
9	5		DAL
10	6		DEN
11	7		DET
12	8		ELP
13	9		HOU
14	10		LOS
15	11		MIA
16	12		NEW
17	13		NOL
18	14		NYC
19	15		PHI
20	16		PHO
21	17		SEA
22	18		SFR
23	19		SLC
24	20		SNA
25	21		SND
26	22		SPM
27	23		WAS
28	24		COW
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
47			2/13/2019	UT							
48			2/14/2019	VT							
49			2/15/2019	VA							
50			2/16/2019	WA							
51			2/17/2019	WV							
52			2/18/2019	WI							
53			2/19/2019	WY							
54			2/20/2019								
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56			2/22/2019								
57			2/23/2019								
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60			2/26/2019								
61			2/27/2019								
62			2/28/2019								
63			3/1/2019								
64			3/2/2019								
65			3/3/2019								
66			3/4/2019								
67			3/5/2019								
68			3/6/2019								
69			3/7/2019								
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83			3/21/2019								
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85			3/23/2019								
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90			3/28/2019								
91			3/29/2019								
92			3/30/2019								

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
93			3/31/2019								
94			4/1/2019								
95			4/2/2019								
96			4/3/2019								
97			4/4/2019								
98			4/5/2019								
99			4/6/2019								
100			4/7/2019								
101			4/8/2019								
102			4/9/2019								
103			4/10/2019								
104			4/11/2019								
105			4/12/2019								
106			4/13/2019								
107			4/14/2019								
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110			4/17/2019								
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113			4/20/2019								
114			4/21/2019								
115			4/22/2019								
116			4/23/2019								
117			4/24/2019								
118			4/25/2019								
119			4/26/2019								
120			4/27/2019								
121			4/28/2019								
122			4/29/2019								
123			4/30/2019								
124			5/1/2019								
125			5/2/2019								
126			5/3/2019								
127			5/4/2019								
128			5/5/2019								
129			5/6/2019								
130			5/7/2019								
131			5/8/2019								
132			5/9/2019								
133			5/10/2019								
134			5/11/2019								
135			5/12/2019								
136			5/13/2019								
137			5/14/2019								
138			5/15/2019								

AMERICAN OVERSIGHT

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94	90		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
139			5/16/2019								
140			5/17/2019								
141			5/18/2019								
142			5/19/2019								
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183			6/29/2019								
184			6/30/2019								

AMERICAN OVERSIGHT

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139	135		
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183	179		
184	180		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
185			7/1/2019								
186			7/2/2019								
187			7/3/2019								
188			7/4/2019								
189			7/5/2019								
190			7/6/2019								
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195			7/11/2019								
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213			7/29/2019								
214			7/30/2019								
215			7/31/2019								
216			8/1/2019								
217			8/2/2019								
218			8/3/2019								
219			8/4/2019								
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222			8/7/2019								
223			8/8/2019								
224			8/9/2019								
225			8/10/2019								
226			8/11/2019								
227			8/12/2019								
228			8/13/2019								
229			8/14/2019								
230			8/15/2019								

AMERICAN OVERSIGHT

	L	M	N
185	181		
186	182		
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224	220		
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227	223		
228	224		
229	225		
230	226		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
231			8/16/2019								
232			8/17/2019								
233			8/18/2019								
234			8/19/2019								
235			8/20/2019								
236			8/21/2019								
237			8/22/2019								
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244			8/29/2019								
245			8/30/2019								
246			8/31/2019								
247			9/1/2019								
248			9/2/2019								
249			9/3/2019								
250			9/4/2019								
251			9/5/2019								
252			9/6/2019								
253			9/7/2019								
254			9/8/2019								
255			9/9/2019								
256			9/10/2019								
257			9/11/2019								
258			9/12/2019								
259			9/13/2019								
260			9/14/2019								
261			9/15/2019								
262			9/16/2019								
263			9/17/2019								
264			9/18/2019								
265			9/19/2019								
266			9/20/2019								
267			9/21/2019								
268			9/22/2019								
269			9/23/2019								
270			9/24/2019								
271			9/25/2019								
272			9/26/2019								
273			9/27/2019								
274			9/28/2019								
275			9/29/2019								
276			9/30/2019								

AMERICAN OVERSIGHT

	L	M	N
231	227		
232	228		
233	229		
234	230		
235	231		
236	232		
237	233		
238	234		
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240	236		
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264	260		
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267	263		
268	264		
269	265		
270	266		
271	267		
272	268		
273	269		
274	270		
275	271		
276	272		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
277			10/1/2019								
278			10/2/2019								
279			10/3/2019								
280			10/4/2019								
281			10/5/2019								
282			10/6/2019								
283			10/7/2019								
284			10/8/2019								
285			10/9/2019								
286			10/10/2019								
287			10/11/2019								
288			10/12/2019								
289			10/13/2019								
290			10/14/2019								
291			10/15/2019								
292			10/16/2019								
293			10/17/2019								
294			10/18/2019								
295			10/19/2019								
296			10/20/2019								
297			10/21/2019								
298			10/22/2019								
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300			10/24/2019								
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302			10/26/2019								
303			10/27/2019								
304			10/28/2019								
305			10/29/2019								
306			10/30/2019								
307			10/31/2019								
308			11/1/2019								
309			11/2/2019								
310			11/3/2019								
311			11/4/2019								
312			11/5/2019								
313			11/6/2019								
314			11/7/2019								
315			11/8/2019								
316			11/9/2019								
317			11/10/2019								
318			11/11/2019								
319			11/12/2019								
320			11/13/2019								
321			11/14/2019								
322			11/15/2019								

AMERICAN OVERSIGHT

	L	M	N
277	273		
278	274		
279	275		
280	276		
281	277		
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322	318		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
323			11/16/2019								
324			11/17/2019								
325			11/18/2019								
326			11/19/2019								
327			11/20/2019								
328			11/21/2019								
329			11/22/2019								
330			11/23/2019								
331			11/24/2019								
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333			11/26/2019								
334			11/27/2019								
335			11/28/2019								
336			11/29/2019								
337			11/30/2019								
338			12/1/2019								
339			12/2/2019								
340			12/3/2019								
341			12/4/2019								
342			12/5/2019								
343			12/6/2019								
344			12/7/2019								
345			12/8/2019								
346			12/9/2019								
347			12/10/2019								
348			12/11/2019								
349			12/12/2019								
350			12/13/2019								
351			12/14/2019								
352			12/15/2019								
353			12/16/2019								
354			12/17/2019								
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357			12/20/2019								
358			12/21/2019								
359			12/22/2019								
360			12/23/2019								
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363			12/26/2019								
364			12/27/2019								
365			12/28/2019								
366			12/29/2019								
367			12/30/2019								
368			12/31/2019								

AMERICAN OVERSIGHT

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324	320		
325	321		
326	322		
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331	327		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
369			1/1/2020								
370			1/2/2020								
371			1/3/2020								
372			1/4/2020								
373			1/5/2020								
374			1/6/2020								
375			1/7/2020								
376			1/8/2020								
377			1/9/2020								
378			1/10/2020								
379			1/11/2020								
380			1/12/2020								
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383			1/15/2020								
384			1/16/2020								
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386			1/18/2020								
387			1/19/2020								
388			1/20/2020								
389			1/21/2020								
390			1/22/2020								
391			1/23/2020								
392			1/24/2020								
393			1/25/2020								
394			1/26/2020								
395			1/27/2020								
396			1/28/2020								
397			1/29/2020								
398			1/30/2020								
399			1/31/2020								
400			2/1/2020								
401			2/2/2020								
402			2/3/2020								
403			2/4/2020								
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406			2/7/2020								
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408			2/9/2020								
409			2/10/2020								
410			2/11/2020								
411			2/12/2020								
412			2/13/2020								
413			2/14/2020								
414			2/15/2020								

AMERICAN OVERSIGHT

	L	M	N
369	365		
370	366		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
415			2/16/2020								
416			2/17/2020								
417			2/18/2020								
418			2/19/2020								
419			2/20/2020								
420			2/21/2020								
421			2/22/2020								
422			2/23/2020								
423			2/24/2020								
424			2/25/2020								
425			2/26/2020								
426			2/27/2020								
427			2/28/2020								
428			2/29/2020								
429			3/1/2020								
430			3/2/2020								
431			3/3/2020								
432			3/4/2020								
433			3/5/2020								
434			3/6/2020								
435			3/7/2020								
436			3/8/2020								
437			3/9/2020								
438			3/10/2020								
439			3/11/2020								
440			3/12/2020								
441			3/13/2020								
442			3/14/2020								
443			3/15/2020								
444			3/16/2020								
445			3/17/2020								
446			3/18/2020								
447			3/19/2020								
448			3/20/2020								
449			3/21/2020								
450			3/22/2020								
451			3/23/2020								
452			3/24/2020								
453			3/25/2020								
454			3/26/2020								
455			3/27/2020								
456			3/28/2020								
457			3/29/2020								
458			3/30/2020								
459			3/31/2020								
460			4/1/2020								

AMERICAN OVERSIGHT

	L	M	N
415	411		
416	412		
417	413		
418	414		
419	415		
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460	456		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
461			4/2/2020								
462			4/3/2020								
463			4/4/2020								
464			4/5/2020								
465			4/6/2020								
466			4/7/2020								
467			4/8/2020								
468			4/9/2020								
469			4/10/2020								
470			4/11/2020								
471			4/12/2020								
472			4/13/2020								
473			4/14/2020								
474			4/15/2020								
475			4/16/2020								
476			4/17/2020								
477			4/18/2020								
478			4/19/2020								
479			4/20/2020								
480			4/21/2020								
481			4/22/2020								
482			4/23/2020								
483			4/24/2020								
484			4/25/2020								
485			4/26/2020								
486			4/27/2020								
487			4/28/2020								
488			4/29/2020								
489			4/30/2020								
490			5/1/2020								
491			5/2/2020								
492			5/3/2020								
493			5/4/2020								
494			5/5/2020								
495			5/6/2020								
496			5/7/2020								
497			5/8/2020								
498			5/9/2020								
499			5/10/2020								
500			5/11/2020								
501			5/12/2020								
502			5/13/2020								
503			5/14/2020								
504			5/15/2020								
505			5/16/2020								
506			5/17/2020								

AMERICAN OVERSIGHT

	L	M	N
461	457		
462	458		
463	459		
464	460		
465	461		
466	462		
467	463		
468	464		
469	465		
470	466		
471	467		
472	468		
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474	470		
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476	472		
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503	499		
504	500		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
507			5/18/2020								
508			5/19/2020								
509			5/20/2020								
510			5/21/2020								
511			5/22/2020								
512			5/23/2020								
513			5/24/2020								
514			5/25/2020								
515			5/26/2020								
516			5/27/2020								
517			5/28/2020								
518			5/29/2020								
519			5/30/2020								
520			5/31/2020								
521			6/1/2020								
522			6/2/2020								
523			6/3/2020								
524			6/4/2020								
525			6/5/2020								
526			6/6/2020								
527			6/7/2020								
528			6/8/2020								
529			6/9/2020								
530			6/10/2020								
531			6/11/2020								
532			6/12/2020								
533			6/13/2020								
534			6/14/2020								
535			6/15/2020								
536			6/16/2020								
537			6/17/2020								
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539			6/19/2020								
540			6/20/2020								
541			6/21/2020								
542			6/22/2020								
543			6/23/2020								
544			6/24/2020								
545			6/25/2020								
546			6/26/2020								
547			6/27/2020								
548			6/28/2020								
549			6/29/2020								
550			6/30/2020								
551			7/1/2020								
552			7/2/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
553			7/3/2020								
554			7/4/2020								
555			7/5/2020								
556			7/6/2020								
557			7/7/2020								
558			7/8/2020								
559			7/9/2020								
560			7/10/2020								
561			7/11/2020								
562			7/12/2020								
563			7/13/2020								
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565			7/15/2020								
566			7/16/2020								
567			7/17/2020								
568			7/18/2020								
569			7/19/2020								
570			7/20/2020								
571			7/21/2020								
572			7/22/2020								
573			7/23/2020								
574			7/24/2020								
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576			7/26/2020								
577			7/27/2020								
578			7/28/2020								
579			7/29/2020								
580			7/30/2020								
581			7/31/2020								
582			8/1/2020								
583			8/2/2020								
584			8/3/2020								
585			8/4/2020								
586			8/5/2020								
587			8/6/2020								
588			8/7/2020								
589			8/8/2020								
590			8/9/2020								
591			8/10/2020								
592			8/11/2020								
593			8/12/2020								
594			8/13/2020								
595			8/14/2020								
596			8/15/2020								
597			8/16/2020								
598			8/17/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
599			8/18/2020								
600			8/19/2020								
601			8/20/2020								
602			8/21/2020								
603			8/22/2020								
604			8/23/2020								
605			8/24/2020								
606			8/25/2020								
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611			8/30/2020								
612			8/31/2020								
613			9/1/2020								
614			9/2/2020								
615			9/3/2020								
616			9/4/2020								
617			9/5/2020								
618			9/6/2020								
619			9/7/2020								
620			9/8/2020								
621			9/9/2020								
622			9/10/2020								
623			9/11/2020								
624			9/12/2020								
625			9/13/2020								
626			9/14/2020								
627			9/15/2020								
628			9/16/2020								
629			9/17/2020								
630			9/18/2020								
631			9/19/2020								
632			9/20/2020								
633			9/21/2020								
634			9/22/2020								
635			9/23/2020								
636			9/24/2020								
637			9/25/2020								
638			9/26/2020								
639			9/27/2020								
640			9/28/2020								
641			9/29/2020								
642			9/30/2020								
643			10/1/2020								
644			10/2/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
645			10/3/2020								
646			10/4/2020								
647			10/5/2020								
648			10/6/2020								
649			10/7/2020								
650			10/8/2020								
651			10/9/2020								
652			10/10/2020								
653			10/11/2020								
654			10/12/2020								
655			10/13/2020								
656			10/14/2020								
657			10/15/2020								
658			10/16/2020								
659			10/17/2020								
660			10/18/2020								
661			10/19/2020								
662			10/20/2020								
663			10/21/2020								
664			10/22/2020								
665			10/23/2020								
666			10/24/2020								
667			10/25/2020								
668			10/26/2020								
669			10/27/2020								
670			10/28/2020								
671			10/29/2020								
672			10/30/2020								
673			10/31/2020								
674			11/1/2020								
675			11/2/2020								
676			11/3/2020								
677			11/4/2020								
678			11/5/2020								
679			11/6/2020								
680			11/7/2020								
681			11/8/2020								
682			11/9/2020								
683			11/10/2020								
684			11/11/2020								
685			11/12/2020								
686			11/13/2020								
687			11/14/2020								
688			11/15/2020								
689			11/16/2020								
690			11/17/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
691			11/18/2020								
692			11/19/2020								
693			11/20/2020								
694			11/21/2020								
695			11/22/2020								
696			11/23/2020								
697			11/24/2020								
698			11/25/2020								
699			11/26/2020								
700			11/27/2020								
701			11/28/2020								
702			11/29/2020								
703			11/30/2020								
704			12/1/2020								
705			12/2/2020								
706			12/3/2020								
707			12/4/2020								
708			12/5/2020								
709			12/6/2020								
710			12/7/2020								
711			12/8/2020								
712			12/9/2020								
713			12/10/2020								
714			12/11/2020								
715			12/12/2020								
716			12/13/2020								
717			12/14/2020								
718			12/15/2020								
719			12/16/2020								
720			12/17/2020								
721			12/18/2020								
722			12/19/2020								
723			12/20/2020								
724			12/21/2020								
725			12/22/2020								
726			12/23/2020								
727			12/24/2020								
728			12/25/2020								
729			12/26/2020								
730			12/27/2020								
731			12/28/2020								
732			12/29/2020								
733			12/30/2020								
734			12/31/2020								
735			1/1/2021								
736			1/2/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
737			1/3/2021								
738			1/4/2021								
739			1/5/2021								
740			1/6/2021								
741			1/7/2021								
742			1/8/2021								
743			1/9/2021								
744			1/10/2021								
745			1/11/2021								
746			1/12/2021								
747			1/13/2021								
748			1/14/2021								
749			1/15/2021								
750			1/16/2021								
751			1/17/2021								
752			1/18/2021								
753			1/19/2021								
754			1/20/2021								
755			1/21/2021								
756			1/22/2021								
757			1/23/2021								
758			1/24/2021								
759			1/25/2021								
760			1/26/2021								
761			1/27/2021								
762			1/28/2021								
763			1/29/2021								
764			1/30/2021								
765			1/31/2021								
766			2/1/2021								
767			2/2/2021								
768			2/3/2021								
769			2/4/2021								
770			2/5/2021								
771			2/6/2021								
772			2/7/2021								
773			2/8/2021								
774			2/9/2021								
775			2/10/2021								
776			2/11/2021								
777			2/12/2021								
778			2/13/2021								
779			2/14/2021								
780			2/15/2021								
781			2/16/2021								
782			2/17/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
783			2/18/2021								
784			2/19/2021								
785			2/20/2021								
786			2/21/2021								
787			2/22/2021								
788			2/23/2021								
789			2/24/2021								
790			2/25/2021								
791			2/26/2021								
792			2/27/2021								
793			2/28/2021								
794			3/1/2021								
795			3/2/2021								
796			3/3/2021								
797			3/4/2021								
798			3/5/2021								
799			3/6/2021								
800			3/7/2021								
801			3/8/2021								
802			3/9/2021								
803			3/10/2021								
804			3/11/2021								
805			3/12/2021								
806			3/13/2021								
807			3/14/2021								
808			3/15/2021								
809			3/16/2021								
810			3/17/2021								
811			3/18/2021								
812			3/19/2021								
813			3/20/2021								
814			3/21/2021								
815			3/22/2021								
816			3/23/2021								
817			3/24/2021								
818			3/25/2021								
819			3/26/2021								
820			3/27/2021								
821			3/28/2021								
822			3/29/2021								
823			3/30/2021								
824			3/31/2021								
825			4/1/2021								
826			4/2/2021								
827			4/3/2021								
828			4/4/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
829			4/5/2021								
830			4/6/2021								
831			4/7/2021								
832			4/8/2021								
833			4/9/2021								
834			4/10/2021								
835			4/11/2021								
836			4/12/2021								
837			4/13/2021								
838			4/14/2021								
839			4/15/2021								
840			4/16/2021								
841			4/17/2021								
842			4/18/2021								
843			4/19/2021								
844			4/20/2021								
845			4/21/2021								
846			4/22/2021								
847			4/23/2021								
848			4/24/2021								
849			4/25/2021								
850			4/26/2021								
851			4/27/2021								
852			4/28/2021								
853			4/29/2021								
854			4/30/2021								
855			5/1/2021								
856			5/2/2021								
857			5/3/2021								
858			5/4/2021								
859			5/5/2021								
860			5/6/2021								
861			5/7/2021								
862			5/8/2021								
863			5/9/2021								
864			5/10/2021								
865			5/11/2021								
866			5/12/2021								
867			5/13/2021								
868			5/14/2021								
869			5/15/2021								
870			5/16/2021								
871			5/17/2021								
872			5/18/2021								
873			5/19/2021								
874			5/20/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
875			5/21/2021								
876			5/22/2021								
877			5/23/2021								
878			5/24/2021								
879			5/25/2021								
880			5/26/2021								
881			5/27/2021								
882			5/28/2021								
883			5/29/2021								
884			5/30/2021								
885			5/31/2021								
886			6/1/2021								
887			6/2/2021								
888			6/3/2021								
889			6/4/2021								
890			6/5/2021								
891			6/6/2021								
892			6/7/2021								
893			6/8/2021								
894			6/9/2021								
895			6/10/2021								
896			6/11/2021								
897			6/12/2021								
898			6/13/2021								
899			6/14/2021								
900			6/15/2021								
901			6/16/2021								
902			6/17/2021								
903			6/18/2021								
904			6/19/2021								
905			6/20/2021								
906			6/21/2021								
907			6/22/2021								
908			6/23/2021								
909			6/24/2021								
910			6/25/2021								
911			6/26/2021								
912			6/27/2021								
913			6/28/2021								
914			6/29/2021								
915			6/30/2021								
916			7/1/2021								
917			7/2/2021								
918			7/3/2021								
919			7/4/2021								
920			7/5/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
921			7/6/2021								
922			7/7/2021								
923			7/8/2021								
924			7/9/2021								
925			7/10/2021								
926			7/11/2021								
927			7/12/2021								
928			7/13/2021								
929			7/14/2021								
930			7/15/2021								
931			7/16/2021								
932			7/17/2021								
933			7/18/2021								
934			7/19/2021								
935			7/20/2021								
936			7/21/2021								
937			7/22/2021								
938			7/23/2021								
939			7/24/2021								
940			7/25/2021								
941			7/26/2021								
942			7/27/2021								
943			7/28/2021								
944			7/29/2021								
945			7/30/2021								
946			7/31/2021								
947			8/1/2021								
948			8/2/2021								
949			8/3/2021								
950			8/4/2021								
951			8/5/2021								
952			8/6/2021								
953			8/7/2021								
954			8/8/2021								
955			8/9/2021								
956			8/10/2021								
957			8/11/2021								
958			8/12/2021								
959			8/13/2021								
960			8/14/2021								
961			8/15/2021								
962			8/16/2021								
963			8/17/2021								
964			8/18/2021								
965			8/19/2021								
966			8/20/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
967			8/21/2021								
968			8/22/2021								
969			8/23/2021								
970			8/24/2021								
971			8/25/2021								
972			8/26/2021								
973			8/27/2021								
974			8/28/2021								
975			8/29/2021								
976			8/30/2021								
977			8/31/2021								
978			9/1/2021								
979			9/2/2021								
980			9/3/2021								
981			9/4/2021								
982			9/5/2021								
983			9/6/2021								
984			9/7/2021								
985			9/8/2021								
986			9/9/2021								
987			9/10/2021								
988			9/11/2021								
989			9/12/2021								
990			9/13/2021								
991			9/14/2021								
992			9/15/2021								
993			9/16/2021								
994			9/17/2021								
995			9/18/2021								
996			9/19/2021								
997			9/20/2021								
998			9/21/2021								
999			9/22/2021								
1000			9/23/2021								
1001			9/24/2021								
1002			9/25/2021								
1003			9/26/2021								
1004			9/27/2021								
1005			9/28/2021								
1006			9/29/2021								
1007			9/30/2021								
1008			10/1/2021								
1009			10/2/2021								
1010			10/3/2021								
1011			10/4/2021								
1012			10/5/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1013			10/6/2021								
1014			10/7/2021								
1015			10/8/2021								
1016			10/9/2021								
1017			10/10/2021								
1018			10/11/2021								
1019			10/12/2021								
1020			10/13/2021								
1021			10/14/2021								
1022			10/15/2021								
1023			10/16/2021								
1024			10/17/2021								
1025			10/18/2021								
1026			10/19/2021								
1027			10/20/2021								
1028			10/21/2021								
1029			10/22/2021								
1030			10/23/2021								
1031			10/24/2021								
1032			10/25/2021								
1033			10/26/2021								
1034			10/27/2021								
1035			10/28/2021								
1036			10/29/2021								
1037			10/30/2021								
1038			10/31/2021								
1039			11/1/2021								
1040			11/2/2021								
1041			11/3/2021								
1042			11/4/2021								
1043			11/5/2021								
1044			11/6/2021								
1045			11/7/2021								
1046			11/8/2021								
1047			11/9/2021								
1048			11/10/2021								
1049			11/11/2021								
1050			11/12/2021								
1051			11/13/2021								
1052			11/14/2021								
1053			11/15/2021								
1054			11/16/2021								
1055			11/17/2021								
1056			11/18/2021								
1057			11/19/2021								
1058			11/20/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1059			11/21/2021								
1060			11/22/2021								
1061			11/23/2021								
1062			11/24/2021								
1063			11/25/2021								
1064			11/26/2021								
1065			11/27/2021								
1066			11/28/2021								
1067			11/29/2021								
1068			11/30/2021								
1069			12/1/2021								
1070			12/2/2021								
1071			12/3/2021								
1072			12/4/2021								
1073			12/5/2021								
1074			12/6/2021								
1075			12/7/2021								
1076			12/8/2021								
1077			12/9/2021								
1078			12/10/2021								
1079			12/11/2021								
1080			12/12/2021								
1081			12/13/2021								
1082			12/14/2021								
1083			12/15/2021								
1084			12/16/2021								
1085			12/17/2021								
1086			12/18/2021								
1087			12/19/2021								
1088			12/20/2021								
1089			12/21/2021								
1090			12/22/2021								
1091			12/23/2021								
1092			12/24/2021								
1093			12/25/2021								
1094			12/26/2021								
1095			12/27/2021								
1096			12/28/2021								
1097			12/29/2021								
1098			12/30/2021								
1099			12/31/2021								
1100			1/1/2022								
1101			1/2/2022								
1102			1/3/2022								
1103			1/4/2022								
1104			1/5/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1105			1/6/2022								
1106			1/7/2022								
1107			1/8/2022								
1108			1/9/2022								
1109			1/10/2022								
1110			1/11/2022								
1111			1/12/2022								
1112			1/13/2022								
1113			1/14/2022								
1114			1/15/2022								
1115			1/16/2022								
1116			1/17/2022								
1117			1/18/2022								
1118			1/19/2022								
1119			1/20/2022								
1120			1/21/2022								
1121			1/22/2022								
1122			1/23/2022								
1123			1/24/2022								
1124			1/25/2022								
1125			1/26/2022								
1126			1/27/2022								
1127			1/28/2022								
1128			1/29/2022								
1129			1/30/2022								
1130			1/31/2022								
1131			2/1/2022								
1132			2/2/2022								
1133			2/3/2022								
1134			2/4/2022								
1135			2/5/2022								
1136			2/6/2022								
1137			2/7/2022								
1138			2/8/2022								
1139			2/9/2022								
1140			2/10/2022								
1141			2/11/2022								
1142			2/12/2022								
1143			2/13/2022								
1144			2/14/2022								
1145			2/15/2022								
1146			2/16/2022								
1147			2/17/2022								
1148			2/18/2022								
1149			2/19/2022								
1150			2/20/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1151			2/21/2022								
1152			2/22/2022								
1153			2/23/2022								
1154			2/24/2022								
1155			2/25/2022								
1156			2/26/2022								
1157			2/27/2022								
1158			2/28/2022								
1159			3/1/2022								
1160			3/2/2022								
1161			3/3/2022								
1162			3/4/2022								
1163			3/5/2022								
1164			3/6/2022								
1165			3/7/2022								
1166			3/8/2022								
1167			3/9/2022								
1168			3/10/2022								
1169			3/11/2022								
1170			3/12/2022								
1171			3/13/2022								
1172			3/14/2022								
1173			3/15/2022								
1174			3/16/2022								
1175			3/17/2022								
1176			3/18/2022								
1177			3/19/2022								
1178			3/20/2022								
1179			3/21/2022								
1180			3/22/2022								
1181			3/23/2022								
1182			3/24/2022								
1183			3/25/2022								
1184			3/26/2022								
1185			3/27/2022								
1186			3/28/2022								
1187			3/29/2022								
1188			3/30/2022								
1189			3/31/2022								
1190			4/1/2022								
1191			4/2/2022								
1192			4/3/2022								
1193			4/4/2022								
1194			4/5/2022								
1195			4/6/2022								
1196			4/7/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1197			4/8/2022								
1198			4/9/2022								
1199			4/10/2022								
1200			4/11/2022								
1201			4/12/2022								
1202			4/13/2022								
1203			4/14/2022								
1204			4/15/2022								
1205			4/16/2022								
1206			4/17/2022								
1207			4/18/2022								
1208			4/19/2022								
1209			4/20/2022								
1210			4/21/2022								
1211			4/22/2022								
1212			4/23/2022								
1213			4/24/2022								
1214			4/25/2022								
1215			4/26/2022								
1216			4/27/2022								
1217			4/28/2022								
1218			4/29/2022								
1219			4/30/2022								
1220			5/1/2022								
1221			5/2/2022								
1222			5/3/2022								
1223			5/4/2022								
1224			5/5/2022								
1225			5/6/2022								
1226			5/7/2022								
1227			5/8/2022								
1228			5/9/2022								
1229			5/10/2022								
1230			5/11/2022								
1231			5/12/2022								
1232			5/13/2022								
1233			5/14/2022								
1234			5/15/2022								
1235			5/16/2022								
1236			5/17/2022								
1237			5/18/2022								
1238			5/19/2022								
1239			5/20/2022								
1240			5/21/2022								
1241			5/22/2022								
1242			5/23/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1243			5/24/2022								
1244			5/25/2022								
1245			5/26/2022								
1246			5/27/2022								
1247			5/28/2022								
1248			5/29/2022								
1249			5/30/2022								
1250			5/31/2022								
1251			6/1/2022								
1252			6/2/2022								
1253			6/3/2022								
1254			6/4/2022								
1255			6/5/2022								
1256			6/6/2022								
1257			6/7/2022								
1258			6/8/2022								
1259			6/9/2022								
1260			6/10/2022								
1261			6/11/2022								
1262			6/12/2022								
1263			6/13/2022								
1264			6/14/2022								
1265			6/15/2022								
1266			6/16/2022								
1267			6/17/2022								
1268			6/18/2022								
1269			6/19/2022								
1270			6/20/2022								
1271			6/21/2022								
1272			6/22/2022								
1273			6/23/2022								
1274			6/24/2022								
1275			6/25/2022								
1276			6/26/2022								
1277			6/27/2022								
1278			6/28/2022								
1279			6/29/2022								
1280			6/30/2022								
1281			7/1/2022								
1282			7/2/2022								
1283			7/3/2022								
1284			7/4/2022								
1285			7/5/2022								
1286			7/6/2022								
1287			7/7/2022								
1288			7/8/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1289			7/9/2022								
1290			7/10/2022								
1291			7/11/2022								
1292			7/12/2022								
1293			7/13/2022								
1294			7/14/2022								
1295			7/15/2022								
1296			7/16/2022								
1297			7/17/2022								
1298			7/18/2022								
1299			7/19/2022								
1300			7/20/2022								
1301			7/21/2022								
1302			7/22/2022								
1303			7/23/2022								
1304			7/24/2022								
1305			7/25/2022								
1306			7/26/2022								
1307			7/27/2022								
1308			7/28/2022								
1309			7/29/2022								
1310			7/30/2022								
1311			7/31/2022								
1312			8/1/2022								
1313			8/2/2022								
1314			8/3/2022								
1315			8/4/2022								
1316			8/5/2022								
1317			8/6/2022								
1318			8/7/2022								
1319			8/8/2022								
1320			8/9/2022								
1321			8/10/2022								
1322			8/11/2022								
1323			8/12/2022								
1324			8/13/2022								
1325			8/14/2022								
1326			8/15/2022								
1327			8/16/2022								
1328			8/17/2022								
1329			8/18/2022								
1330			8/19/2022								
1331			8/20/2022								
1332			8/21/2022								
1333			8/22/2022								
1334			8/23/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1335			8/24/2022								
1336			8/25/2022								
1337			8/26/2022								
1338			8/27/2022								
1339			8/28/2022								
1340			8/29/2022								
1341			8/30/2022								
1342			8/31/2022								
1343			9/1/2022								
1344			9/2/2022								
1345			9/3/2022								
1346			9/4/2022								
1347			9/5/2022								
1348			9/6/2022								
1349			9/7/2022								
1350			9/8/2022								
1351			9/9/2022								
1352			9/10/2022								
1353			9/11/2022								
1354			9/12/2022								
1355			9/13/2022								
1356			9/14/2022								
1357			9/15/2022								
1358			9/16/2022								
1359			9/17/2022								
1360			9/18/2022								
1361			9/19/2022								
1362			9/20/2022								
1363			9/21/2022								
1364			9/22/2022								
1365			9/23/2022								
1366			9/24/2022								
1367			9/25/2022								
1368			9/26/2022								
1369			9/27/2022								
1370			9/28/2022								
1371			9/29/2022								
1372			9/30/2022								
1373			10/1/2022								
1374			10/2/2022								
1375			10/3/2022								
1376			10/4/2022								
1377			10/5/2022								
1378			10/6/2022								
1379			10/7/2022								
1380			10/8/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1381			10/9/2022								
1382			10/10/2022								
1383			10/11/2022								
1384			10/12/2022								
1385			10/13/2022								
1386			10/14/2022								
1387			10/15/2022								
1388			10/16/2022								
1389			10/17/2022								
1390			10/18/2022								
1391			10/19/2022								
1392			10/20/2022								
1393			10/21/2022								
1394			10/22/2022								
1395			10/23/2022								
1396			10/24/2022								
1397			10/25/2022								
1398			10/26/2022								
1399			10/27/2022								
1400			10/28/2022								
1401			10/29/2022								
1402			10/30/2022								
1403			10/31/2022								
1404			11/1/2022								
1405			11/2/2022								
1406			11/3/2022								
1407			11/4/2022								
1408			11/5/2022								
1409			11/6/2022								
1410			11/7/2022								
1411			11/8/2022								
1412			11/9/2022								
1413			11/10/2022								
1414			11/11/2022								
1415			11/12/2022								
1416			11/13/2022								
1417			11/14/2022								
1418			11/15/2022								
1419			11/16/2022								
1420			11/17/2022								
1421			11/18/2022								
1422			11/19/2022								
1423			11/20/2022								
1424			11/21/2022								
1425			11/22/2022								
1426			11/23/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1427			11/24/2022								
1428			11/25/2022								
1429			11/26/2022								
1430			11/27/2022								
1431			11/28/2022								
1432			11/29/2022								
1433			11/30/2022								
1434			12/1/2022								
1435			12/2/2022								
1436			12/3/2022								
1437			12/4/2022								
1438			12/5/2022								
1439			12/6/2022								
1440			12/7/2022								
1441			12/8/2022								
1442			12/9/2022								
1443			12/10/2022								
1444			12/11/2022								
1445			12/12/2022								
1446			12/13/2022								
1447			12/14/2022								
1448			12/15/2022								
1449			12/16/2022								
1450			12/17/2022								
1451			12/18/2022								
1452			12/19/2022								
1453			12/20/2022								
1454			12/21/2022								
1455			12/22/2022								
1456			12/23/2022								
1457			12/24/2022								
1458			12/25/2022								
1459			12/26/2022								
1460			12/27/2022								
1461			12/28/2022								
1462			12/29/2022								
1463			12/30/2022								
1464			12/31/2022								
1465			1/1/2023								
1466			1/2/2023								
1467			1/3/2023								
1468			1/4/2023								
1469			1/5/2023								
1470			1/6/2023								
1471			1/7/2023								
1472			1/8/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1473			1/9/2023								
1474			1/10/2023								
1475			1/11/2023								
1476			1/12/2023								
1477			1/13/2023								
1478			1/14/2023								
1479			1/15/2023								
1480			1/16/2023								
1481			1/17/2023								
1482			1/18/2023								
1483			1/19/2023								
1484			1/20/2023								
1485			1/21/2023								
1486			1/22/2023								
1487			1/23/2023								
1488			1/24/2023								
1489			1/25/2023								
1490			1/26/2023								
1491			1/27/2023								
1492			1/28/2023								
1493			1/29/2023								
1494			1/30/2023								
1495			1/31/2023								
1496			2/1/2023								
1497			2/2/2023								
1498			2/3/2023								
1499			2/4/2023								
1500			2/5/2023								
1501			2/6/2023								
1502			2/7/2023								
1503			2/8/2023								
1504			2/9/2023								
1505			2/10/2023								
1506			2/11/2023								
1507			2/12/2023								
1508			2/13/2023								
1509			2/14/2023								
1510			2/15/2023								
1511			2/16/2023								
1512			2/17/2023								
1513			2/18/2023								
1514			2/19/2023								
1515			2/20/2023								
1516			2/21/2023								
1517			2/22/2023								
1518			2/23/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1519			2/24/2023								
1520			2/25/2023								
1521			2/26/2023								
1522			2/27/2023								
1523			2/28/2023								
1524			3/1/2023								
1525			3/2/2023								
1526			3/3/2023								
1527			3/4/2023								
1528			3/5/2023								
1529			3/6/2023								
1530			3/7/2023								
1531			3/8/2023								
1532			3/9/2023								
1533			3/10/2023								
1534			3/11/2023								
1535			3/12/2023								
1536			3/13/2023								
1537			3/14/2023								
1538			3/15/2023								
1539			3/16/2023								
1540			3/17/2023								
1541			3/18/2023								
1542			3/19/2023								
1543			3/20/2023								
1544			3/21/2023								
1545			3/22/2023								
1546			3/23/2023								
1547			3/24/2023								
1548			3/25/2023								
1549			3/26/2023								
1550			3/27/2023								
1551			3/28/2023								
1552			3/29/2023								
1553			3/30/2023								
1554			3/31/2023								
1555			4/1/2023								
1556			4/2/2023								
1557			4/3/2023								
1558			4/4/2023								
1559			4/5/2023								
1560			4/6/2023								
1561			4/7/2023								
1562			4/8/2023								
1563			4/9/2023								
1564			4/10/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1565			4/11/2023								
1566			4/12/2023								
1567			4/13/2023								
1568			4/14/2023								
1569			4/15/2023								
1570			4/16/2023								
1571			4/17/2023								
1572			4/18/2023								
1573			4/19/2023								
1574			4/20/2023								
1575			4/21/2023								
1576			4/22/2023								
1577			4/23/2023								
1578			4/24/2023								
1579			4/25/2023								
1580			4/26/2023								
1581			4/27/2023								
1582			4/28/2023								
1583			4/29/2023								
1584			4/30/2023								
1585			5/1/2023								
1586			5/2/2023								
1587			5/3/2023								
1588			5/4/2023								
1589			5/5/2023								
1590			5/6/2023								
1591			5/7/2023								
1592			5/8/2023								
1593			5/9/2023								
1594			5/10/2023								
1595			5/11/2023								
1596			5/12/2023								
1597			5/13/2023								
1598			5/14/2023								
1599			5/15/2023								
1600			5/16/2023								
1601			5/17/2023								
1602			5/18/2023								
1603			5/19/2023								
1604			5/20/2023								
1605			5/21/2023								
1606			5/22/2023								
1607			5/23/2023								
1608			5/24/2023								
1609			5/25/2023								
1610			5/26/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1611			5/27/2023								
1612			5/28/2023								
1613			5/29/2023								
1614			5/30/2023								
1615			5/31/2023								
1616			6/1/2023								
1617			6/2/2023								
1618			6/3/2023								
1619			6/4/2023								
1620			6/5/2023								
1621			6/6/2023								
1622			6/7/2023								
1623			6/8/2023								
1624			6/9/2023								
1625			6/10/2023								
1626			6/11/2023								
1627			6/12/2023								
1628			6/13/2023								
1629			6/14/2023								
1630			6/15/2023								
1631			6/16/2023								
1632			6/17/2023								
1633			6/18/2023								
1634			6/19/2023								
1635			6/20/2023								
1636			6/21/2023								
1637			6/22/2023								
1638			6/23/2023								
1639			6/24/2023								
1640			6/25/2023								
1641			6/26/2023								
1642			6/27/2023								
1643			6/28/2023								
1644			6/29/2023								
1645			6/30/2023								
1646			7/1/2023								
1647			7/2/2023								
1648			7/3/2023								
1649			7/4/2023								
1650			7/5/2023								
1651			7/6/2023								
1652			7/7/2023								
1653			7/8/2023								
1654			7/9/2023								
1655			7/10/2023								
1656			7/11/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1657			7/12/2023								
1658			7/13/2023								
1659			7/14/2023								
1660			7/15/2023								
1661			7/16/2023								
1662			7/17/2023								
1663			7/18/2023								
1664			7/19/2023								
1665			7/20/2023								
1666			7/21/2023								
1667			7/22/2023								
1668			7/23/2023								
1669			7/24/2023								
1670			7/25/2023								
1671			7/26/2023								
1672			7/27/2023								
1673			7/28/2023								
1674			7/29/2023								
1675			7/30/2023								
1676			7/31/2023								
1677			8/1/2023								
1678			8/2/2023								
1679			8/3/2023								
1680			8/4/2023								
1681			8/5/2023								
1682			8/6/2023								
1683			8/7/2023								
1684			8/8/2023								
1685			8/9/2023								
1686			8/10/2023								
1687			8/11/2023								
1688			8/12/2023								
1689			8/13/2023								
1690			8/14/2023								
1691			8/15/2023								
1692			8/16/2023								
1693			8/17/2023								
1694			8/18/2023								
1695			8/19/2023								
1696			8/20/2023								
1697			8/21/2023								
1698			8/22/2023								
1699			8/23/2023								
1700			8/24/2023								
1701			8/25/2023								
1702			8/26/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1703			8/27/2023								
1704			8/28/2023								
1705			8/29/2023								
1706			8/30/2023								
1707			8/31/2023								
1708			9/1/2023								
1709			9/2/2023								
1710			9/3/2023								
1711			9/4/2023								
1712			9/5/2023								
1713			9/6/2023								
1714			9/7/2023								
1715			9/8/2023								
1716			9/9/2023								
1717			9/10/2023								
1718			9/11/2023								
1719			9/12/2023								
1720			9/13/2023								
1721			9/14/2023								
1722			9/15/2023								
1723			9/16/2023								
1724			9/17/2023								
1725			9/18/2023								
1726			9/19/2023								
1727			9/20/2023								
1728			9/21/2023								
1729			9/22/2023								
1730			9/23/2023								
1731			9/24/2023								
1732			9/25/2023								
1733			9/26/2023								
1734			9/27/2023								
1735			9/28/2023								
1736			9/29/2023								
1737			9/30/2023								
1738			10/1/2023								
1739			10/2/2023								
1740			10/3/2023								
1741			10/4/2023								
1742			10/5/2023								
1743			10/6/2023								
1744			10/7/2023								
1745			10/8/2023								
1746			10/9/2023								
1747			10/10/2023								
1748			10/11/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1749			10/12/2023								
1750			10/13/2023								
1751			10/14/2023								
1752			10/15/2023								
1753			10/16/2023								
1754			10/17/2023								
1755			10/18/2023								
1756			10/19/2023								
1757			10/20/2023								
1758			10/21/2023								
1759			10/22/2023								
1760			10/23/2023								
1761			10/24/2023								
1762			10/25/2023								
1763			10/26/2023								
1764			10/27/2023								
1765			10/28/2023								
1766			10/29/2023								
1767			10/30/2023								
1768			10/31/2023								
1769			11/1/2023								
1770			11/2/2023								
1771			11/3/2023								
1772			11/4/2023								
1773			11/5/2023								
1774			11/6/2023								
1775			11/7/2023								
1776			11/8/2023								
1777			11/9/2023								
1778			11/10/2023								
1779			11/11/2023								
1780			11/12/2023								
1781			11/13/2023								
1782			11/14/2023								
1783			11/15/2023								
1784			11/16/2023								
1785			11/17/2023								
1786			11/18/2023								
1787			11/19/2023								
1788			11/20/2023								
1789			11/21/2023								
1790			11/22/2023								
1791			11/23/2023								
1792			11/24/2023								
1793			11/25/2023								
1794			11/26/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1795			11/27/2023								
1796			11/28/2023								
1797			11/29/2023								
1798			11/30/2023								
1799			12/1/2023								
1800			12/2/2023								
1801			12/3/2023								
1802			12/4/2023								
1803			12/5/2023								
1804			12/6/2023								
1805			12/7/2023								
1806			12/8/2023								
1807			12/9/2023								
1808			12/10/2023								
1809			12/11/2023								
1810			12/12/2023								
1811			12/13/2023								
1812			12/14/2023								
1813			12/15/2023								
1814			12/16/2023								
1815			12/17/2023								
1816			12/18/2023								
1817			12/19/2023								
1818			12/20/2023								
1819			12/21/2023								
1820			12/22/2023								
1821			12/23/2023								
1822			12/24/2023								
1823			12/25/2023								
1824			12/26/2023								
1825			12/27/2023								
1826			12/28/2023								
1827			12/29/2023								
1828			12/30/2023								
1829			12/31/2023								
1830			1/1/2024								
1831			1/2/2024								
1832			1/3/2024								
1833			1/4/2024								
1834			1/5/2024								
1835			1/6/2024								
1836			1/7/2024								
1837			1/8/2024								
1838			1/9/2024								
1839			1/10/2024								
1840			1/11/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1841			1/12/2024								
1842			1/13/2024								
1843			1/14/2024								
1844			1/15/2024								
1845			1/16/2024								
1846			1/17/2024								
1847			1/18/2024								
1848			1/19/2024								
1849			1/20/2024								
1850			1/21/2024								
1851			1/22/2024								
1852			1/23/2024								
1853			1/24/2024								
1854			1/25/2024								
1855			1/26/2024								
1856			1/27/2024								
1857			1/28/2024								
1858			1/29/2024								
1859			1/30/2024								
1860			1/31/2024								
1861			2/1/2024								
1862			2/2/2024								
1863			2/3/2024								
1864			2/4/2024								
1865			2/5/2024								
1866			2/6/2024								
1867			2/7/2024								
1868			2/8/2024								
1869			2/9/2024								
1870			2/10/2024								
1871			2/11/2024								
1872			2/12/2024								
1873			2/13/2024								
1874			2/14/2024								
1875			2/15/2024								
1876			2/16/2024								
1877			2/17/2024								
1878			2/18/2024								
1879			2/19/2024								
1880			2/20/2024								
1881			2/21/2024								
1882			2/22/2024								
1883			2/23/2024								
1884			2/24/2024								
1885			2/25/2024								
1886			2/26/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1887			2/27/2024								
1888			2/28/2024								
1889			2/29/2024								
1890			3/1/2024								
1891			3/2/2024								
1892			3/3/2024								
1893			3/4/2024								
1894			3/5/2024								
1895			3/6/2024								
1896			3/7/2024								
1897			3/8/2024								
1898			3/9/2024								
1899			3/10/2024								
1900			3/11/2024								
1901			3/12/2024								
1902			3/13/2024								
1903			3/14/2024								
1904			3/15/2024								
1905			3/16/2024								
1906			3/17/2024								
1907			3/18/2024								
1908			3/19/2024								
1909			3/20/2024								
1910			3/21/2024								
1911			3/22/2024								
1912			3/23/2024								
1913			3/24/2024								
1914			3/25/2024								
1915			3/26/2024								
1916			3/27/2024								
1917			3/28/2024								
1918			3/29/2024								
1919			3/30/2024								
1920			3/31/2024								
1921			4/1/2024								
1922			4/2/2024								
1923			4/3/2024								
1924			4/4/2024								
1925			4/5/2024								
1926			4/6/2024								
1927			4/7/2024								
1928			4/8/2024								
1929			4/9/2024								
1930			4/10/2024								
1931			4/11/2024								
1932			4/12/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1933			4/13/2024								
1934			4/14/2024								
1935			4/15/2024								
1936			4/16/2024								
1937			4/17/2024								
1938			4/18/2024								
1939			4/19/2024								
1940			4/20/2024								
1941			4/21/2024								
1942			4/22/2024								
1943			4/23/2024								
1944			4/24/2024								
1945			4/25/2024								
1946			4/26/2024								
1947			4/27/2024								
1948			4/28/2024								
1949			4/29/2024								
1950			4/30/2024								
1951			5/1/2024								
1952			5/2/2024								
1953			5/3/2024								
1954			5/4/2024								
1955			5/5/2024								
1956			5/6/2024								
1957			5/7/2024								
1958			5/8/2024								
1959			5/9/2024								
1960			5/10/2024								
1961			5/11/2024								
1962			5/12/2024								
1963			5/13/2024								
1964			5/14/2024								
1965			5/15/2024								
1966			5/16/2024								
1967			5/17/2024								
1968			5/18/2024								
1969			5/19/2024								
1970			5/20/2024								
1971			5/21/2024								
1972			5/22/2024								
1973			5/23/2024								
1974			5/24/2024								
1975			5/25/2024								
1976			5/26/2024								
1977			5/27/2024								
1978			5/28/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1979			5/29/2024								
1980			5/30/2024								
1981			5/31/2024								
1982			6/1/2024								
1983			6/2/2024								
1984			6/3/2024								
1985			6/4/2024								
1986			6/5/2024								
1987			6/6/2024								
1988			6/7/2024								
1989			6/8/2024								
1990			6/9/2024								
1991			6/10/2024								
1992			6/11/2024								
1993			6/12/2024								
1994			6/13/2024								
1995			6/14/2024								
1996			6/15/2024								
1997			6/16/2024								
1998			6/17/2024								
1999			6/18/2024								
2000			6/19/2024								
2001			6/20/2024								
2002			6/21/2024								
2003			6/22/2024								
2004			6/23/2024								
2005			6/24/2024								
2006			6/25/2024								
2007			6/26/2024								
2008			6/27/2024								
2009			6/28/2024								
2010			6/29/2024								
2011			6/30/2024								
2012			7/1/2024								
2013			7/2/2024								
2014			7/3/2024								
2015			7/4/2024								
2016			7/5/2024								
2017			7/6/2024								
2018			7/7/2024								
2019			7/8/2024								
2020			7/9/2024								
2021			7/10/2024								
2022			7/11/2024								
2023			7/12/2024								
2024			7/13/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2025			7/14/2024								
2026			7/15/2024								
2027			7/16/2024								
2028			7/17/2024								
2029			7/18/2024								
2030			7/19/2024								
2031			7/20/2024								
2032			7/21/2024								
2033			7/22/2024								
2034			7/23/2024								
2035			7/24/2024								
2036			7/25/2024								
2037			7/26/2024								
2038			7/27/2024								
2039			7/28/2024								
2040			7/29/2024								
2041			7/30/2024								
2042			7/31/2024								
2043			8/1/2024								
2044			8/2/2024								
2045			8/3/2024								
2046			8/4/2024								
2047			8/5/2024								
2048			8/6/2024								
2049			8/7/2024								
2050			8/8/2024								
2051			8/9/2024								
2052			8/10/2024								
2053			8/11/2024								
2054			8/12/2024								
2055			8/13/2024								
2056			8/14/2024								
2057			8/15/2024								
2058			8/16/2024								
2059			8/17/2024								
2060			8/18/2024								
2061			8/19/2024								
2062			8/20/2024								
2063			8/21/2024								
2064			8/22/2024								
2065			8/23/2024								
2066			8/24/2024								
2067			8/25/2024								
2068			8/26/2024								
2069			8/27/2024								
2070			8/28/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2071			8/29/2024								
2072			8/30/2024								
2073			8/31/2024								
2074			9/1/2024								
2075			9/2/2024								
2076			9/3/2024								
2077			9/4/2024								
2078			9/5/2024								
2079			9/6/2024								
2080			9/7/2024								
2081			9/8/2024								
2082			9/9/2024								
2083			9/10/2024								
2084			9/11/2024								
2085			9/12/2024								
2086			9/13/2024								
2087			9/14/2024								
2088			9/15/2024								
2089			9/16/2024								
2090			9/17/2024								
2091			9/18/2024								
2092			9/19/2024								
2093			9/20/2024								
2094			9/21/2024								
2095			9/22/2024								
2096			9/23/2024								
2097			9/24/2024								
2098			9/25/2024								
2099			9/26/2024								
2100			9/27/2024								
2101			9/28/2024								
2102			9/29/2024								
2103			9/30/2024								
2104			10/1/2024								
2105			10/2/2024								
2106			10/3/2024								
2107			10/4/2024								
2108			10/5/2024								
2109			10/6/2024								
2110			10/7/2024								
2111			10/8/2024								
2112			10/9/2024								
2113			10/10/2024								
2114			10/11/2024								
2115			10/12/2024								
2116			10/13/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2117			10/14/2024								
2118			10/15/2024								
2119			10/16/2024								
2120			10/17/2024								
2121			10/18/2024								
2122			10/19/2024								
2123			10/20/2024								
2124			10/21/2024								
2125			10/22/2024								
2126			10/23/2024								
2127			10/24/2024								
2128			10/25/2024								
2129			10/26/2024								
2130			10/27/2024								
2131			10/28/2024								
2132			10/29/2024								
2133			10/30/2024								
2134			10/31/2024								
2135			11/1/2024								
2136			11/2/2024								
2137			11/3/2024								
2138			11/4/2024								
2139			11/5/2024								
2140			11/6/2024								
2141			11/7/2024								
2142			11/8/2024								
2143			11/9/2024								
2144			11/10/2024								
2145			11/11/2024								
2146			11/12/2024								
2147			11/13/2024								
2148			11/14/2024								
2149			11/15/2024								
2150			11/16/2024								
2151			11/17/2024								
2152			11/18/2024								
2153			11/19/2024								
2154			11/20/2024								
2155			11/21/2024								
2156			11/22/2024								
2157			11/23/2024								
2158			11/24/2024								
2159			11/25/2024								
2160			11/26/2024								
2161			11/27/2024								
2162			11/28/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2163			11/29/2024								
2164			11/30/2024								
2165			12/1/2024								
2166			12/2/2024								
2167			12/3/2024								
2168			12/4/2024								
2169			12/5/2024								
2170			12/6/2024								
2171			12/7/2024								
2172			12/8/2024								
2173			12/9/2024								
2174			12/10/2024								
2175			12/11/2024								
2176			12/12/2024								
2177			12/13/2024								
2178			12/14/2024								
2179			12/15/2024								
2180			12/16/2024								
2181			12/17/2024								
2182			12/18/2024								
2183			12/19/2024								
2184			12/20/2024								
2185			12/21/2024								
2186			12/22/2024								
2187			12/23/2024								
2188			12/24/2024								
2189			12/25/2024								
2190			12/26/2024								
2191			12/27/2024								
2192			12/28/2024								
2193			12/29/2024								
2194			12/30/2024								
2195			12/31/2024								
2196			1/1/2025								
2197			1/2/2025								
2198			1/3/2025								
2199			1/4/2025								
2200			1/5/2025								
2201			1/6/2025								
2202			1/7/2025								
2203			1/8/2025								
2204			1/9/2025								
2205			1/10/2025								
2206			1/11/2025								
2207			1/12/2025								
2208			1/13/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2209			1/14/2025								
2210			1/15/2025								
2211			1/16/2025								
2212			1/17/2025								
2213			1/18/2025								
2214			1/19/2025								
2215			1/20/2025								
2216			1/21/2025								
2217			1/22/2025								
2218			1/23/2025								
2219			1/24/2025								
2220			1/25/2025								
2221			1/26/2025								
2222			1/27/2025								
2223			1/28/2025								
2224			1/29/2025								
2225			1/30/2025								
2226			1/31/2025								
2227			2/1/2025								
2228			2/2/2025								
2229			2/3/2025								
2230			2/4/2025								
2231			2/5/2025								
2232			2/6/2025								
2233			2/7/2025								
2234			2/8/2025								
2235			2/9/2025								
2236			2/10/2025								
2237			2/11/2025								
2238			2/12/2025								
2239			2/13/2025								
2240			2/14/2025								
2241			2/15/2025								
2242			2/16/2025								
2243			2/17/2025								
2244			2/18/2025								
2245			2/19/2025								
2246			2/20/2025								
2247			2/21/2025								
2248			2/22/2025								
2249			2/23/2025								
2250			2/24/2025								
2251			2/25/2025								
2252			2/26/2025								
2253			2/27/2025								
2254			2/28/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2255			3/1/2025								
2256			3/2/2025								
2257			3/3/2025								
2258			3/4/2025								
2259			3/5/2025								
2260			3/6/2025								
2261			3/7/2025								
2262			3/8/2025								
2263			3/9/2025								
2264			3/10/2025								
2265			3/11/2025								
2266			3/12/2025								
2267			3/13/2025								
2268			3/14/2025								
2269			3/15/2025								
2270			3/16/2025								
2271			3/17/2025								
2272			3/18/2025								
2273			3/19/2025								
2274			3/20/2025								
2275			3/21/2025								
2276			3/22/2025								
2277			3/23/2025								
2278			3/24/2025								
2279			3/25/2025								
2280			3/26/2025								
2281			3/27/2025								
2282			3/28/2025								
2283			3/29/2025								
2284			3/30/2025								
2285			3/31/2025								
2286			4/1/2025								
2287			4/2/2025								
2288			4/3/2025								
2289			4/4/2025								
2290			4/5/2025								
2291			4/6/2025								
2292			4/7/2025								
2293			4/8/2025								
2294			4/9/2025								
2295			4/10/2025								
2296			4/11/2025								
2297			4/12/2025								
2298			4/13/2025								
2299			4/14/2025								
2300			4/15/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2301			4/16/2025								
2302			4/17/2025								
2303			4/18/2025								
2304			4/19/2025								
2305			4/20/2025								
2306			4/21/2025								
2307			4/22/2025								
2308			4/23/2025								
2309			4/24/2025								
2310			4/25/2025								
2311			4/26/2025								
2312			4/27/2025								
2313			4/28/2025								
2314			4/29/2025								
2315			4/30/2025								
2316			5/1/2025								
2317			5/2/2025								
2318			5/3/2025								
2319			5/4/2025								
2320			5/5/2025								
2321			5/6/2025								
2322			5/7/2025								
2323			5/8/2025								
2324			5/9/2025								
2325			5/10/2025								
2326			5/11/2025								
2327			5/12/2025								
2328			5/13/2025								
2329			5/14/2025								
2330			5/15/2025								
2331			5/16/2025								
2332			5/17/2025								
2333			5/18/2025								
2334			5/19/2025								
2335			5/20/2025								
2336			5/21/2025								
2337			5/22/2025								
2338			5/23/2025								
2339			5/24/2025								
2340			5/25/2025								
2341			5/26/2025								
2342			5/27/2025								
2343			5/28/2025								
2344			5/29/2025								
2345			5/30/2025								
2346			5/31/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2347			6/1/2025								
2348			6/2/2025								
2349			6/3/2025								
2350			6/4/2025								
2351			6/5/2025								
2352			6/6/2025								
2353			6/7/2025								
2354			6/8/2025								
2355			6/9/2025								
2356			6/10/2025								
2357			6/11/2025								
2358			6/12/2025								
2359			6/13/2025								
2360			6/14/2025								
2361			6/15/2025								
2362			6/16/2025								
2363			6/17/2025								
2364			6/18/2025								
2365			6/19/2025								
2366			6/20/2025								
2367			6/21/2025								
2368			6/22/2025								
2369			6/23/2025								
2370			6/24/2025								
2371			6/25/2025								
2372			6/26/2025								
2373			6/27/2025								
2374			6/28/2025								
2375			6/29/2025								
2376			6/30/2025								
2377			7/1/2025								
2378			7/2/2025								
2379			7/3/2025								
2380			7/4/2025								
2381			7/5/2025								
2382			7/6/2025								
2383			7/7/2025								
2384			7/8/2025								
2385			7/9/2025								
2386			7/10/2025								
2387			7/11/2025								
2388			7/12/2025								
2389			7/13/2025								
2390			7/14/2025								
2391			7/15/2025								
2392			7/16/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2393			7/17/2025								
2394			7/18/2025								
2395			7/19/2025								
2396			7/20/2025								
2397			7/21/2025								
2398			7/22/2025								
2399			7/23/2025								
2400			7/24/2025								
2401			7/25/2025								
2402			7/26/2025								
2403			7/27/2025								
2404			7/28/2025								
2405			7/29/2025								
2406			7/30/2025								
2407			7/31/2025								
2408			8/1/2025								
2409			8/2/2025								
2410			8/3/2025								
2411			8/4/2025								
2412			8/5/2025								
2413			8/6/2025								
2414			8/7/2025								
2415			8/8/2025								
2416			8/9/2025								
2417			8/10/2025								
2418			8/11/2025								
2419			8/12/2025								
2420			8/13/2025								
2421			8/14/2025								
2422			8/15/2025								
2423			8/16/2025								
2424			8/17/2025								
2425			8/18/2025								
2426			8/19/2025								
2427			8/20/2025								
2428			8/21/2025								
2429			8/22/2025								
2430			8/23/2025								
2431			8/24/2025								
2432			8/25/2025								
2433			8/26/2025								
2434			8/27/2025								
2435			8/28/2025								
2436			8/29/2025								
2437			8/30/2025								
2438			8/31/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2439			9/1/2025								
2440			9/2/2025								
2441			9/3/2025								
2442			9/4/2025								
2443			9/5/2025								
2444			9/6/2025								
2445			9/7/2025								
2446			9/8/2025								
2447			9/9/2025								
2448			9/10/2025								
2449			9/11/2025								
2450			9/12/2025								
2451			9/13/2025								
2452			9/14/2025								
2453			9/15/2025								
2454			9/16/2025								
2455			9/17/2025								
2456			9/18/2025								
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2482			10/14/2025								
2483			10/15/2025								
2484			10/16/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2485			10/17/2025								
2486			10/18/2025								
2487			10/19/2025								
2488			10/20/2025								
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2500			11/1/2025								
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2530			12/1/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2531			12/2/2025								
2532			12/3/2025								
2533			12/4/2025								
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2574			1/14/2026								
2575			1/15/2026								
2576			1/16/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2577			1/17/2026								
2578			1/18/2026								
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2616			2/25/2026								
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2618			2/27/2026								
2619			2/28/2026								
2620			3/1/2026								
2621			3/2/2026								
2622			3/3/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2623			3/4/2026								
2624			3/5/2026								
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2654			4/4/2026								
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2666			4/16/2026								
2667			4/17/2026								
2668			4/18/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2669			4/19/2026								
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2671			4/21/2026								
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2712			6/1/2026								
2713			6/2/2026								
2714			6/3/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2715			6/4/2026								
2716			6/5/2026								
2717			6/6/2026								
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2758			7/17/2026								
2759			7/18/2026								
2760			7/19/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2761			7/20/2026								
2762			7/21/2026								
2763			7/22/2026								
2764			7/23/2026								
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2799			8/27/2026								
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2801			8/29/2026								
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2803			8/31/2026								
2804			9/1/2026								
2805			9/2/2026								
2806			9/3/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
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2810			9/7/2026								
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2849			10/16/2026								
2850			10/17/2026								
2851			10/18/2026								
2852			10/19/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2853			10/20/2026								
2854			10/21/2026								
2855			10/22/2026								
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2895			12/1/2026								
2896			12/2/2026								
2897			12/3/2026								
2898			12/4/2026								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2899			12/5/2026								
2900			12/6/2026								
2901			12/7/2026								
2902			12/8/2026								
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2941			1/16/2027								
2942			1/17/2027								
2943			1/18/2027								
2944			1/19/2027								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2945			1/20/2027								
2946			1/21/2027								
2947			1/22/2027								
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2954			1/29/2027								
2955			1/30/2027								
2956			1/31/2027								

AMERICAN OVERSIGHT

Quality of Medical Care (QMC) Inspection Worksheet

IHSC QMC for Facilities

*Indicates Required Field

Facility Information						
Facility Name:*	Rio Grande Detention Center					
AOR:*	SNA					
Address:	1001 San Rio Blvd.					
City:	Laredo		**County:**	Webb		
State:*	TX	**Zip:**		78046		
Inspection Information						
Start Date:*	6/24/2019					
End Date:*	6/28/2019					
Organization:*		IHSC				
# Detainees at Time of Visit:		734				
Total Facility Population at Time of Visit:		1859				
Facility Capacity:		1900				
Notes:						
Reviewer Information						
Lead Reviewer Name:*	b(6), b(7)©			**Date Signed:***	1/17/2020	
Signature:	X					
HQ Use Only:				*1/3/2019*		

AMERICAN OVERSIGHT

	A	B	C	D
1		**Compliance Dashboard**		
2	**Subject Area**	**Description**	**Compliance**	
3	ASM	Asthma	100%	
4	CG	Complaints and Grievance	0	*Total Number
5	CM	Continuity of Medications	100%	
6	DC	Dental Care	95%	
7	DM	Diabetes	43%	
8	DSA	Diagnostic Services and Specialty Care Access	100%	
9	EED	Evaluation of Care Prior to Emergency Department	80%	
10	HA	Health Assessment	100%	
11	HIV	Human Immunodeficiency Virus		
12	HTN	Hypertension	75%	
13	LT	Laboratory Testing	0%	
14	MR	Medical Recordkeeping	100%	
15	MAR	Medication Administration Records		
16	MHS	Mental Health Screen	100%	
17	MHT	Mental Health Treatment Planning	100%	
18	PG	Pregnant Women		
19	SZ	Seizure Disorder	70%	
20	SS	Suicide Screening		
21	TD	Treatment of Disability		
22	UC	Urgent Care (Sick Call)	95%	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**IGSA STAFFING MATRIX**			
2							**1 FTE = 40 hours / per week*
3							
4	**Position**	**# FTE Filled**	**# FTE Vacant**	**Total FTE Per Staffing Model**	**# Day Shift**	**# Evening Shift**	**# Night Shift**
5							
6	**C.N.A.**						
7	**Dental Assistant**						
8	**Dentist**						
9	**EMT**						
10	**H.S.A.**						
11	**LVN/LPN**						
12	**MH Counselor**						
13	**MRT**						
14	**NP/PA**						
15	**Nurse Manager**						
16	**Paramedic**						
17	**Pharmacist**						
18	**Pharmacy Tech**						
19	**Physician**						
20	**Psychiatrist**						
21	**Psychologist**						
22	**RN**						
23	**Social Worker**						
24	**X-ray Tech**						
25	**Other 1**						
26	**Other 2**						
27							
28	**TOTAL**	0	0	0	0	0	0

AMERICAN OVERSIGHT

	A
1	
2	
3	**INTRODUCTION TO THE QMC**
4	These Quality of Medical Care (QMC) audit tools focus on the assessment of clinical performance using a set of standardized measures. The measures are based on either nationally-accepted clinical guidelines or industry best practices regarding healthcare services for chronic diseases, such as National Commission for Correctional Healthcare, National Institutes of Health, American Diabetes Association, etc. Measurement of clinical performance is only one aspect of a facility quality assessment. It is an adjunct, not a substitute, for assessment of the effectiveness of policies and procedures, sanitation and hygiene, space and equipment, etc.
5	• These tools are designed to provide a snapshot of care for current or recent detainees, focused on areas of high risk.
6	• The data collected can be used to analyze opportunities for improvement, for tracking and trending performance over a period of time, and for cross-comparisons with other facilities.
7	• The measures on each audit tool are "proxy" measures which can be used to generalize about the health care for a specific situation or condition based on the answers to each question. For example, there are eight measures on the diabetes audit tool. If performance on these measures is acceptable, it is assumed that the overall care for diabetics is acceptable.
8	• The recommended sampling design is intended to measure recent care provided in the facility, generally on patients who have been in custody for enough time to provide expected care, follow-through and measurable outcomes. For example, the health assessment sample is taken from a list of detainees in custody ≥ 14 days.
9	• In most cases, the recommended sample size will provide a reliable picture of care that can be generalized.
10	• While the goal is 100% compliance, the performance objective for most of the audit tools is ≥ 90%. That is, a facility is meeting expectations when performance on each measure meets or exceeds 90%.
11	• The performance objective for the audit tool on ambulatory sensitive conditions is 100%.
12	• In general, the answers are either "yes," "no," or "not applicable due to length of stay" (N/A - LOS) or "not applicable – not due to length of stay" (N/A - NLOS). In general, a 'yes' response indicates that the measure has been met and a 'no' response indicates the measure has not been met. Two exceptions to this are noted in the section below.
13	
14	**AUDIT TOOL COMPLETION**
15	Reviewers are required to complete each audit tool. If there are no detainees who meet the criteria for a particular audit tool, this should be noted on the worksheet by clicking the appropriate box. If there are no detainees who meet the criteria, but there are general questions to answer on the tool, the answers to these questions should still be filled out. If the number of detainees who meet the audit tool criteria is less than the recommended sample size, the reviewer should answer the measures for the number of detainees available and add a note in the overall remarks section about why the full sample size was not reviewed. If certain measures are not applicable to a particular detainee, the reviewer will select the 'NA – LOS' answer, if the reason it was not applicable is related to the shortened stay of the detainee in the facility. If the reason is not applicable due to other reasons, the reviewer will select 'NA – Not LOS' as the answer. Reviewers should note that in item #2 in the Evaluation of Care Prior to Emergency Department/Hospital Visit for Conditions Sensitive to Ambulatory Care audit tool a 'no' response is the desired answer that would indicate that the criteria was met. Thus if all responses are 'no' for this item, this reflects 100% compliance with this measure. The same should be noted by reviewers for item #5 in the Suicide Screening audit tool. A 'no' response is the desired answer that would indicate the criteria was met.
16	
17	**TIPS FOR REVIEWERS**
18	• Keep control of the medical record sample selection. Select the records to review from the primary or secondary source identified on each audit tool. Ask the medical records staff to return the list of selected records with the corresponding stack of records to know why those records were requested and what proportion of the requests were not available.

AMERICAN OVERSIGHT

	A
19	• Take note of the proportion of the requested medical records that were not available and the proportion of laboratory and diagnostic reports that were not filed and acknowledged within the medical record. These are indicators of medical record system problems.
20	• Try to maintain the sample size. If several records requested are not available, select the same number of additional records to maintain the expected sample size.
21	• If a question asks for clinical judgment as to timeliness or appropriateness and the reviewer is unsure of the answer, make a simple note of the circumstances and discuss with a physician before finalizing the data. This may be done "back in the office."
22	• Don't neglect to ask for any paper records in facilities that use electronic health records. Many facilities maintain a paper record for certain documents.
23	• Don't hesitate to use a detainee's record for more than one audit tool. If the name shows up on two lists, and it was selected multiple times, use that record again.
24	• Don't make any assumptions about the reason for the absence of medical record documentation for any measure in the audit tools. Inquire with the facility health authority to obtain a clear understanding of the absence of information.
25	• Don't let facility staff select the records for review. This introduces bias, even if not intentional.
26	• Don't confuse the policy governing a certain practice with what was actually done in specific instance. Actual practice should be well-documented in the medical record.
27	• Don't think about calculating a composite score for an audit tool. Composite scores are misleading. Failure to achieve ≥ 90% on any single measure is an opportunity for improvement that can reduce a potential risk to detainees.

AMERICAN OVERSIGHT

	A	B	C
1	**Term**	**Description**	
2	A#	Enter A# in format 123456789. Omit all leading characters such as "A".	
3	N/A - LOS	N/A Due to Length of Stay	
4	N/A - NLOS	N/A Not Due to Length of Stay	
5	ASM	Asthma	
6	CG	Complaints and Grievance	
7	CM	Continuity of Medications	
8	DC	Dental Care	
9	DM	Diabetes	
10	DSA	Diagnostic Services and Specialty Care Access	
11	EED	Evaluation of Care Prior to Emergency Department	
12	HA	Health Assessment	
13	HIV	Human Immunodeficiency Virus	
14	HTN	Hypertension	
15	LT	Laboratory Testing	
16	MR	Medical Recordkeeping	
17	MAR	Medication Administration Records	
18	MHS	Mental Health Screen	
19	MHT	Mental Health Treatment Planning	
20	PG	Pregnant Women	
21	SZ	Seizure Disorder	
22	SS	Suicide Screening	
23	TD	Treatment of Disability	
24	UC	Urgent Care (Sick Call)	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**ASTHMA (MODERATE AND SEVERE)**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		4						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs (Medical Administrative Record).							
6	**Sample:**	10 patients with moderate or severe asthma (for example, those on inhaled or oral steroids), chosen at random, if available.							
7		NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Guidelines:**	National Heath, Lung, and Blood Institute. (Sept., 2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3.							
10		https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf							
11		Peak Expiratory Flow Rates, (Sept, 2016)							
12		http://www.sh.lsuhsc.edu/fammed/outpatientmanual/PeakFlowTables.htm							
13	**Remarks:**	POLICIES REVIEWED: Policy G-01 (Essential) "Chronic Disease Services" is complaint with PBNDS 2008.							
14	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
15									
16				**Facility (f)**					
17	**fASM-1a:**	Does the facility follow a particular clinical practice guideline to manage asthma?						Y	
18 19	**~~fASM-1b:~~**	~~If yes, what is the guideline?~~			~~Federal Bureau of Prisons (BOP) Clinical Practice Guidelines~~				
20									
21				**Clinical (c)**					
22	**cASM-1**	Was patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cASM-2**	Was a peak flow completed at the initial physical exam?							
24	**cASM-3**	Was a peak flow completed at the CC visit or within the last 3 months?							
25	**cASM-4**	Was a chronic disease guideline followed, which addressed disease severity, prescription of medication consistent with severity, and documented degree of control? *This criterion may require physician review. Please note in remarks if physician input was utilized.							
26									
27	**Totals:**		4	4	4	4			
28	**Total Applicable:**		4	4	4	4			
29	**Total Met:**		4	4	4	4			
30	**% Compliance:**	100%	100%	100%	100%	100%			
31				**A#**					
32	**Patient(s)**	**A# (numbers only)**	**cASM-1**	**cASM-2**	**cASM-3**	**cASM-4**			
33	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
34	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
35	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
36	4	b(6), b(7)(c)	Yes	Yes	Yes	Yes			
37	5		Select	Select	Select	Select			
38	6		Select	Select	Select	Select			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
39	7		Select	Select	Select	Select			
40	8		Select	Select	Select	Select			
41	9		Select	Select	Select	Select			
42	10		Select	Select	Select	Select			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1					**DIABETES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		3						
3					10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with diabetes chosen at random, if available.							
7	**Guidelines:**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9	**Remarks:**			Review noted nurses not carrying out doctor's orders for labs in a timely manner.					
10	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		6/27/2019	
11									
12					**Facility (f)**				
13	**fDM-1:**	What clinical practice guideline does the				Federal Bureau of Prisons (BOP) Clinical Practice Guidelines			
14		facility use to manage diabetes?							
15									
16					**Clinical (c)**				
17	**cDM-1**	Was blood sugar measured and recorded on intake?							
18	**cDM-2**	Was patient seen for chronic care by mid-level provider or physician within 14* days of illness identification? (14 days for stable patients. Unstable pa medications (4 or more) should be seen sooner.)							
19	**cDM-3**	Was a baseline HgbA1C performed within 30 days of intake or within the past 3 months?							
20	**cDM-4**	Were lipids measured within one year?							
21	**cDM-5**	Was patient followed at least every 90 days with appropriate vital signs?							
22	**cDM-6**	Was aspirin prescribed, as clinically indicated? *Refer to User Guide for clinical indications.							
23	**cDM-7**	Was degree of control (goal HgbA1C <8.0) documented?							
24	**cDM-8**	Was a strategy to attain diabetes control documented if HgbA1C was above goal?							
25									
26	**Total Applicable:**		3	3	3	3	3	0	3
27	**Total Met:**		3	3	0	0	3	0	0
28	**% Compliance:**	43%	100%	100%	0%	0%	100%		0%
29					**0**				
30	**Patient(s)**	**A# (numbers only)**	**cDM-1**	**cDM-2**	**cDM-3**	**cDM-4**	**cDM-5**	**cDM-6**	**cDM-7**
31	1	b(6), b(7)(c)	Yes	Yes	No	No	Yes	N/A - NLOS	No
32	2	b(6), b(7)(c)	Yes	Yes	No	No	Yes	N/A - NLOS	No
33	3	b(6), b(7)(c)	Yes	Yes	No	No	Yes	N/A - NLOS	No
34	4		Select	Select	Select	Select	Select	Select	Select
35	5		Select	Select	Select	Select	Select	Select	Select
36	6		Select	Select	Select	Select	Select	Select	Select
37	7		Select	Select	Select	Select	Select	Select	Select
38	8		Select	Select	Select	Select	Select	Select	Select
39	9		Select	Select	Select	Select	Select	Select	Select
40	10		Select	Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

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18	atients or those on multiple	
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21		
22		
23		
24		
25		
26	3	
27	0	
28	0%	
29		
30	**cDM-8**	
31	No	
32	No	
33	No	
34	Select	
35	Select	
36	Select	
37	Select	
38	Select	
39	Select	
40	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HIV**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs for current detainees and those detained within the last 6 months.							
6	**Sample:**	10 patients with HIV chosen at random or the universe of HIV-infected detainees, if < 10.							
7		National Institutes of Health. Aids Info.		https://aidsinfo.nih.gov/guidelines			http://nccc.ucsf.edu		
8	**Guidelines:**	University of California, San Francisco. HIV Clinical Consultation Center.							
9		ACA Standard Reference: ACA 2004 4-ALDF-4C-18							
10	**Remarks:**			Type Text Here					
11	**Reviewer:**	Type Text Here				**Date Reviewed:**	Select		
12									
13				**Facility (f)**					
14	~~**fHIV-1:**~~	What clinical practice guideline does the facility							
15		use to manage HIV?					~~Type Text Here~~		
16									
17				**Clinical (c)**					
18	**cHIV-1**	How was HIV status identified? By laboratory, prior medical records or patient report?							
19	**cHIV-2**	Was a CD4+ and viral load completed within 14 days of arrival, or within the last 3 months?							
20	**cHIV-3**	Was patient seen by an HIV or ID specialist within 30 days of HIV identification?							
21	**cHIV-4**	Was antiretroviral treatment considered and documented?							
22	**cHIV-5**	Was the patient seen by a mid-level provider or physician for chronic care at least every 90 days?							
23	**cHIV-6**	Was a chest x-ray completed within 72 hours of problem identification, if not already done?							
24									
25	**Total Applicable:**			0	0	0	0	0	
26	**Total Met:**			0	0	0	0	0	
27	**% Compliance:**								
28									
29	**Patient(s)**	**A# (numbers only)**	**cHIV-1**	**cHIV-2**	**cHIV-3**	**cHIV-4**	**cHIV-5**	**cHIV-6**	
30	1		Select	Select	Select	Select	Select	Select	
31	2		Select	Select	Select	Select	Select	Select	
32	3		Select	Select	Select	Select	Select	Select	
33	4		Select	Select	Select	Select	Select	Select	
34	5		Select	Select	Select	Select	Select	Select	
35	6		Select	Select	Select	Select	Select	Select	
36	7		Select	Select	Select	Select	Select	Select	
37	8		Select	Select	Select	Select	Select	Select	
38	9		Select	Select	Select	Select	Select	Select	
39	10		Select	Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**HYPERTENSION**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for chronic disease and to prevent deterioration in function and cost of unnecessary care.							
5	**Source:**	Chronic disease registry or MARs.							
6	**Sample:**	10 patients with hypertension chosen at random, if available.							
7	**~~Guidelines:~~**	NCCHC Federal Clinical Guidelines							
8		https://www.ncchc.org/federal-clinical-guidelines							
9									
10	**Remarks:**	~~Review noted nurses not carrying out doctor's orders for labs and diagnostic tests in a timely manner. FMC found no EKGs ordered and no labs that were completed. Consistently found that chronic disease guideline was not followed.~~							
11									
12	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
13									
14				**Facility (f)**					
15	**fHTN-1a:**	Does the facility follow a clinical practice guideline to manage hypertension?						Y	
16	**~~fHTN-1b:~~**	~~If yes, what is the guideline?~~			~~Federal Bureau of Prisons (BOP) Clinical Practice Guidelines~~				
17									
18									
19				**Clinical (c)**					
20	**cHTN-1**	Was a blood pressure reading noted at intake?							
21	**cHTN-2**	Was the patient seen by an MD/PA/NP within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
22	**cHTN-3**	If blood pressure was >140 systolic or >90 diastolic, was a treatment plan initiated within 14 days of identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
23	**cHTN-4**	Was a chronic disease guideline, including baseline laboratory testing, followed?							
24									
25	**Total Applicable:**		10	10	10	10			
26	**Total Met:**		10	10	10	0			
27	**% Compliance:**	75%	100%	100%	100%	0%			
28									
29	**Patient(s)**	**A# (numbers only)**	**cHTN-1**	**cHTN-2**	**cHTN-3**	**cHTN-4**			
30	1	b(6), b(7)(c)	Y	Yes	Yes	No			
31	2	b(6), b(7)(c)	Y	Yes	Yes	No			
32	3	b(6), b(7)(c)	Y	Yes	Yes	No			
33	4	b(6), b(7)(c)	Y	Yes	Yes	No			
34	5	b(6), b(7)(c)	Y	Yes	Yes	No			
35	6	b(6), b(7)(c)	Y	Yes	Yes	No			
36	7	b(6), b(7)(c)	Y	Yes	Yes	No			
37	8	b(6), b(7)(c)	Y	Yes	Yes	No			
38	9	b(6), b(7)(c)	Y	Yes	Yes	No			
39	10	b(6), b(7)(c)	Y	Yes	Yes	No			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**SEIZURE DISORDER**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		2					
3				10				
4	**Purpose:**	To prevent deterioration in function and cost of unnecessary care.						
5	**Source:**	Chronic disease registry or MARs.						
6	**Sample:**	10 patients with seizure disorder chosen at random, if available.						
7	**Guidelines:**							
8								
9	**Remarks:**	~~One instance of intake LVN noting Dilantin, but did not note that the detainee had seizures or note on the intake record; note found for bottom bunk on another form that was given to the officer. No appropriate documentation of neurlogical hx.~~						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019	
12								
13				**Facility (f)**				
14	**fSZ-1:**	What clinical practice guideline does the facility		~~Federal Bureau of Prisons (BOP) Clinical Practice Guidelines~~				
15		use to manage seizures?						
16								
17				**Clinical (c)**				
18	**cSZ-1**	Was an appropriate neurological history completed at the initial physical examination?						
19	**cSZ-2**	Was the patient seen in CCC by mid-level provider or physician within 14 days of illness identification? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.						
20	**cSZ-3**	Were serum drug levels performed and acknowledged in the medical record every 3 months until stable, then every 6 months, where indicated?						
21	**cSZ-4**	Was a treatment plan established?						
22	**cSZ-5**	Are there orders for a bottom bunk?						
23								
24	**Total Applicable:**		2	2	1	2	2	
25	**Total Met:**		0	2	1	2	1	
26	**% Compliance:**	70%	0%	100%	100%	100%	50%	
27								
28	**Patient(s)**	**A# (numbers only)**	**cSZ-1**	**cSZ-2**	**cSZ-3**	**cSZ-4**	**cSZ-5**	
29	1	b(6), b(7)(c)	No	Yes	N/A - NLOS	Yes	Yes	
30	2	b(6), b(7)(c)	No	Yes	Yes	Yes	No	
31	3		Select	Select	Select	Select	Select	
32	4		Select	Select	Select	Select	Select	
33	5		Select	Select	Select	Select	Select	
34	6		Select	Select	Select	Select	Select	
35	7		Select	Select	Select	Select	Select	
36	8		Select	Select	Select	Select	Select	
37	9		Select	Select	Select	Select	Select	
38	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1			**CONTINUITY OF MEDICATIONS**						
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess timeliness of medication, as ordered.							
5	**Source:**	Patients with initial intake orders for chronic medications with time urgency, such as HIV medications, Coumadin, psychotropic medication, diabetes medication, or new prescriptions for antibiotics (psychotropic medication must be part of the sample).							
6	**Sample:**	Initially identify 10 patients (if available) from MARs, cross check date of first dose with order date in the medical record.							
7	**Guidelines:**								
8									
9	**Remarks:**	POLICIES REVIEWED: Policy E-12 (Essential) "Continuity of Care During Incarceration" is compliant with PBNDS 2008.							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
12									
13				**Clinical (c)**					
14	**cCM-1**	Period of time from completion of intake screening to the ordering of medications less than 24 hours?							
15	**cCM-2**	Period of time from order to first dose less than 24 hours?							
16									
17	**Total Applicable:**		10	10					
18	**Total Met:**		10	10					
19	**% Compliance:**	100%	100%	100%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cCM-1**	**cCM-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	Yes					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	Yes					
26	5	b(6), b(7)(c)	Yes	Yes					
27	6	b(6), b(7)(c)	Yes	Yes					
28	7	b(6), b(7)(c)	Yes	Yes					
29	8	b(6), b(7)(c)	Yes	Yes					
30	9	b(6), b(7)(c)	Yes	Yes					
31	10	b(6), b(7)(c)	Yes	Yes					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**DENTAL CARE**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess compliance with detention standards and continuity of care.							
5	**Source:**	Dental sick call list or dental referral log.							
6	**Sample:**	10 records (if available) from recent schedule of patients evaluated for a dental complaint, selected for acuity, e.g., on pain medication or antibiotics for toothache.							
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-02, J-E-04, J-E-06; ACA 2004 4-ALDF-4C-20.							
8									
9	**Remarks:**	POLICIES REVIEWED: Policy E-06 (Essential) "Oral Care" is compliant with PBNDS 2008.							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
12									
13				**Clinical (c)**					
14	**cDC-1**	Was patient screened for symptoms during the intake process?							
15	**cDC-2**	Was patient evaluated by a qualified health professional within 48 hours of request?							
16	**cDC-3**	Do dental clinical notes describe findings, diagnosis, treatment, and plans?							
17	**cDC-4**	Was the patient scheduled for follow-up treatment as recommended?							
18									
19	**Total Applicable:**		10	10	10	3			
20	**Total Met:**		9	9	10	3			
21	**% Compliance:**	95%	90%	90%	100%	100%			
22									
23	**Patient(s)**	**A# (numbers only)**	**cDC-1**	**cDC-2**	**cDC-3**	**cDC-4**			
24	1	b(6), b(7)(c)	Y	No	Yes	N/A - NLOS			
25	2	b(6), b(7)(c)	N	Yes	Yes	Yes			
26	3	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
27	4	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
28	5	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
29	6	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
30	7	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
31	8	b(6), b(7)(c)	Y	Yes	Yes	N/A - NLOS			
32	9	b(6), b(7)(c)	y	Yes	Yes	Yes			
33	10	b(6), b(7)(c)	Y	Yes	Yes	Yes			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		2					
3				10				
4	**Purpose:**	To assess timeliness of off-site diagnostic services and specialty care.						
5	**Source:**	Referrals log, medical records or MedPars.						
6	**Sample:**	10 specialty patients (if available) chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.						
7	**Guidelines:**	NCCHC 2014 J-D-05; ACA 2004 4-ALDF-4C-06.						
8								
9	**Remarks:**	POLICIES REVIEWED: Policy D-05 (Important) "Hospital and Specialty Care" is compliant with PBNDS 2008.						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019	
12								
13			**Clinical (c)**					
14	**cDSA-1**	Was there a documented time urgency included on the order for specialty care or diagnostic services?						
15	**cDSA-2**	Was the appointment accomplished within 45 days of the order or within the ordered timeframe, e.g., “return in 90 days”?						
16	**cDSA-3**	Was the patient re-evaluated for deterioration every 30 days until off-site service completed?						
17	**cDSA-4**	Did the facility clinician acknowledge the specialist's report in the medical record within 7 days of the date the service was performed?						
18								
19	**Total Applicable:**			2	2	2	2	
20	**Total Met:**			2	2	2	2	
21	**% Compliance:**	100%		100%	100%	100%	100%	
22								
23	**Patient(s)**	**A# (numbers only)**	**Clinic**	**cDSA-1**	**cDSA-2**	**cDSA-3**	**cDSA-4**	
24	1	b(6), b(7)(c)-EKG	Other	Yes	Yes	Yes	Yes	
25	2	b(6), b(7)(c)-x-ray (TB)	Other	Yes	Yes	Yes	Yes	
26	3		Select	Select	Select	Select	Select	
27	4		Select	Select	Select	Select	Select	
28	5		Select	Select	Select	Select	Select	
29	6		Select	Select	Select	Select	Select	
30	7		Select	Select	Select	Select	Select	
31	8		Select	Select	Select	Select	Select	
32	9		Select	Select	Select	Select	Select	
33	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1	**EVALUATION OF CARE PRIOR TO EMERGENCY DEPARTMENT/HOSPITAL VISIT FOR CONDITIONS SENSITIVE TO AMBULATORY CARE**							
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		2					
3				10				
4	**Purpose:**	To determine whether earlier intervention might have prevented morbidity and cost of outside care. To measure continuity and coordination of care for inbou						
5	**Source:**	Emergency Department (ED) logs.						
6	**Sample:**	Within the past 6 months, 10 patients (if available) sent to ED with ambulatory sensitive conditions, such as seizure, alcohol and/or substance withdrawal, sk tissue infections, DKA, abdominal pain, or chest pain.						
7	**Guidelines:**	NCCHC 2014 J-E-12.						
8	**Remarks:**	POLICIES REVIEWED: Policy E-08 (Essential) "Emergency Services" is complaint with PBNDS 2008. Recommend adding EKG to telephone orders f patients. Obtain EKG and labs earlier before the day that he was sent to the ER. It would have been helpful to have the EKG and labs done earlier on b(6),						
9		detainee was admitted to the hospital. The labs were ordered several times by the Clinical Director, but no labs found on the chart other than those from the h						
10				EKG was ordered.				
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		6/27/20
12								
13			**Clinical (c)**					
14	**cEED-1**	Is there an outbound progress note?						
15	**cEED-2**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for ED/hospital care? If yes, please describe in the remarks the report.*This will require physician review in some cases. If a physician assists with completion of this review, please include his or her name in the repor						
16	**cEED-3**	Is there discharge documentation from the hospital or ED in the chart?						
17	**cEED-4**	Is there an inbound assessment?						
18	**cEED-5**	Does the assessment reflect hospital findings and concurrence or justification for deviation from hospital recommendations?						
19								
20	**Total Applicable:**			2	2	2	2	2
21	**Total Met:**			2	0	2	2	2
22	**% Compliance:**	80%		100%	0%	100%	100%	100%
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cEED-1**	**cEED-2**	**cEED-3**	**cEED-4**	**cEED-5**
25	1	b(6), b(7)(c)	weakness, dizziness, dehydration, cardiac	Yes	Yes	Yes	Yes	Yes
26	2	b(6), b(7)(c)	hyponatremia, hypokalemia, HTN, renal failure	Yes	Yes	Yes	Yes	Yes
27	3			Select	Select	Select	Select	Select
28	4			Select	Select	Select	Select	Select
29	5			Select	Select	Select	Select	Select
30	6			Select	Select	Select	Select	Select
31	7			Select	Select	Select	Select	Select
32	8			Select	Select	Select	Select	Select
33	9			Select	Select	Select	Select	Select
34	10			Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**COMPLAINTS AND GRIEVANCES**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** (please select 0 if no files/patients reviewed)		0					
3				10				
4	**Purpose:**	To assess use of medical grievance data as part of the quality management program.						
5	**Source:**	Facility grievance logs.						
6	**Sample:**	Facility's periodic grievance analyses, with underlying data (grievances and responses). Include no greater than 30 A#'s per grievance category.						
7	**Guidelines:**	NCCHC 2014 J-A-06, J-A-11.						
8								
9	**Remarks:**	POLICIES REVIEWED: Policy A-11 (Essential) "Grievance Mechanism for Health Complaints" is complaint with PBNDS 2008.						
10								
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		Select
12								
13				**Facility (f)**				
14	**fCG-1:**	Does your review of the facility's grievances reveal any possible barriers to care or repetitive concerns that could affect clinical care?						N
15		If yes, please address in the remarks section whether and how the facility uses this information to implement change.						
16	**fCG-2:**	How many medical grievances were submitted over the past 3 months?				0		
17	**fCG-3:**	Of medical grievances submitted over the past three months, how many were appropriately addressed within 5 working days of receipt?				0		
18								
19				**Clinical (c)**				
20	**cCG-1**	What is the A# for each of the grievances submitted over the past 3 months for each category in the table below?						
21	**cCG-2**	What was the number of grievances submitted, by A#, over the past 3 months for each category in the table below?						
22								
23	**Totals:**	0	0	0	0	0	0	0
24								
25	**Patient(s)**	**A# (numbers only)**	**Availability of care (sick call hours, etc.)**	**Denial or refusal of specific request(s) for care**	**Delay(s) in care**	**Competency/professional skillset of medical staff**	**Attitude, demeanor or conduct of staff**	**Other**
26	1		Select	Select	Select	Select	Select	Select
27	2		Select	Select	Select	Select	Select	Select
28	3		Select	Select	Select	Select	Select	Select
29	4		Select	Select	Select	Select	Select	Select
30	5		Select	Select	Select	Select	Select	Select
31	6		Select	Select	Select	Select	Select	Select
32	7		Select	Select	Select	Select	Select	Select
33	8		Select	Select	Select	Select	Select	Select
34	9		Select	Select	Select	Select	Select	Select
35	10		Select	Select	Select	Select	Select	Select

AMERICAN OVERSIGHT

DHS-ICE-20-0618-A-003213

	A	B	C	D	E	F	G	H
1				**HEALTH ASSESSMENT**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		20					
3				10				
4	**Purpose:**	To determine compliance with detention standards to assure continuity and coordination of care for serious medical needs.						
5	**Source:**	Detainees arriving during recent period, at least 2 weeks prior to review, to allow for evaluation of timely follow-up.						
6	**Sample:**	20 medical records chosen at random.						
7	**Guidelines:**	NCCHC 2014 J-E-04; ACA 2004 4-ALDF-4C-24, 4-ALDF-4C-25						
8		POLICIES REVIEWED: Policy E-04 (Essential) "Initial Health Assessment" is compliant with PBNDS 2008. RN completed H&P						
9	**Remarks:**	on seizure and asthma patient. Reviewed the following additional charts with no findings: b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c),						
10		b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c), b(6), b(7)(c).						
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019	
12								
13				**Clinical (c)**				
14	**cHA-1**	Initial screen complete within 12 hours of booking?						
15	**cHA-2**	PPD placed during medical screening and read within 48-72 hours, or chest x-ray is taken, or if PPD is positive by history, chest x-ray is ordered and read?						
16	**cHA-3**	Are detainees who screen positive for mental illness or suicide risk referred for evaluation?						
17	**cHA-4**	Is there timely follow-up for significant findings of acute and chronic conditions? *A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health.						
18	**cHA-5**	Is there a complete health evaluation? Vital signs, adequate medical and behavioral health history, physical examination by licensed MD/PA/NP/RN within 14 days of booking? Patients with HIV, diabetes, dialysis, asthma (on daily meds), and other chronic illness will be seen within 2 business days or addressed by phone and seen on the next business day.						
19				**0**				
20	**Total Applicable:**		10	10	10	10	10	
21	**Total Met:**		10	10	10	10	10	
22	**% Compliance:**	100%	100%	100%	100%	100%	100%	
23								
24	**Patient(s)**	**A# (numbers only)**	**cHA-1**	**cHA-2**	**cHA-3**	**cHA-4**	**cHA-5**	
25	1	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
26	2	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
27	3	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
28	4	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
29	5	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
30	6	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
31	7	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
32	8	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
33	9	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	
34	10	b(6), b(7)(c)	Yes	Yes	Yes	Yes	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**LABORATORY TESTING**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10					
3				10				
4	**Purpose:**	To assess timeliness, continuity, and coordination of care.						
5	**Source:**	Medical records, laboratory logs, sick call logs, and/or chronic care logs.						
6	**Sample:**	10 orders for labs within the last 6 months (refer to User Guide for additional guidance) , if available.						
7	**Guidelines:**							
8	**Remarks:**	POLICIES REVIEWED: Policy D-04 (Important) "Diagnostic Services" is compliant with PBNDS 2008. Labcorp is contracted to pick up and process the labs collected at the facility. For STAT labs, Laredo Medical Center is utilized. -0 of 10 (0%) had blood drawn within one business day of ordered date. -0 of 10 (0%) had report back within 24 hours, as appropriate, for acute labs or within seven days for routine labs. None of the labs for chronic care patients (diabetic, HTN, thyroid detainees) that the physician order were not completed and the results were not in the chart.						
9								
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019	
12								
13			**Clinical (c)**					
14	**cLT-1**	Was blood drawn or test done within 1 business day of ordered date?						
15	**cLT-2**	Was there a report back within 24 hours, as appropriate, for acute labs or within 7 days for routine labs?						
16	**cLT-3**	Was there clinical acknowledgment?						
17	**cLT-4**	Was there an appropriate clinical response?						
18	**cLT-5**	Was patient advised of laboratory results?						
19								
20	**Total Applicable:**		10	10	0	0	0	
21	**Total Met:**		0	0	0	0	0	
22	**% Compliance:**	0%	0%	0%				
23								
24	**Patient(s)**	**A# (numbers only)**	**cLT-1**	**cLT-2**	**cLT-3**	**cLT-4**	**cLT-5**	
25	1	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
26	2	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
27	3	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
28	4	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
29	5	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
30	6	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
31	7	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
32	8	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
33	9	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	
34	10	b(6), b(7)(c)	No	No	N/A	N/A - NLOS	N/A - NLOS	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				**MEDICATION ADMINISTRATION RECORDS**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10						
3				10					
4	**Purpose:**	To assess continuity of ordered care and notification to clinician of poor adherence to medication orders.							
5	**Source:**	MARS.							
6	**Sample:**	MAR and medical record for 10 patients, if available. Medication refusals and/or no shows are defined as those instances in which a patient refuses medications on 3 consecutive days or for 3 consecutive doses and /or 4 or more doses in a week.							
7	**Guidelines:**								
8									
9	**Remarks:**	~~POLICIES REVIEWED: Policy D-01 (Essential) "Pharmaceutical Operations" and Policy D-02 (Essential)"Medication Services" are compliant with PBNDS 2008.~~							
10									
11	**Reviewer:**	b(6), b(7)©			**Date Reviewed:**		6/27/2019		
12									
13				**Facility (f)**					
14	**fMAR-1:**	Does facility have a policy in place stating which medications, if missed a certain number of consecutive doses, require provider notification and/or follow-up?						Y	
15	**~~fMAR-2:~~**	Based on review of current month MARs or previous month's MARs, if available, what						~~0~~	
16		percentage of MARs that have either blanks, consecutive refusals, or no shows on the MARs?							
17	**fMAR-3:**	In the medical record filing area, how many months of MARs are unfiled, not counting unfiled MARs within 14 days of the end of the previous month?						0	
18	**fMAR-4:**	Estimate the percentage of patients on self-administered medication ordered by a provider.						90	
19	**fMAR-5:**	OTCs provided by medical, commissary or both?						Both	
20									
21				**Clinical (c)**					
22	**cMAR-1**	What is the number of refusals and no shows during the previous month for each patient?							
23	**cMAR-2**	Is there documentation in the medical record that the prescribing clinician was notified of consecutive refusals?							
24	**cMAR-3**	Was there an appropriate response from the clinician (i.e., was the patient interviewed or was the prescription changed or discontinued?)							
25									
26	**Total Applicable:**			0	0				
27	**Total Met:**			0	0				
28	**% Compliance:**								
29									
30	**Patient(s)**	**A# (numbers only)**	**cMAR-1**	**cMAR-2**	**cMAR-3**				
31	1	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
32	2	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
33	3	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
34	4	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
35	5	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
36	6	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
37	7	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
38	8	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				
39	9	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
40	10	b(6), b(7)(c)	0	N/A - NLOS	N/A - NLOS				

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G
1				**MEDICAL RECORD-KEEPING PRACTICES**			
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		10				
3							
4	**Purpose:**	To assess completeness of the medical record and appropriateness of medical record practices.					
5	**Source:**	Medical Records, Chronic Care Log, and MARs.					
6	**Sample:**	10 records of detainees with chronic disease, if available.					
7	**Instructions:**	For all answers that are "partial compliance" or "non-compliant", the reviewer should insert a comment in the remarks section of the report. For exa progress notes are legible, but one or two practitioner's notes are barely legible, the appropriate comment would be "Dr. XX's notes are not legible."					
8	**Guidelines:**	NCCHC 2014 J-H-01, J-H-03.					
9							
10	**Remarks:**			POLICIES REVIEWED: Policy H-01 (Essential) "Health Record Format and Contents" is compliant with PBNDS 2008.			
11							
12	**Reviewer:**		b(6), b(7)(c)		**Date Reviewed:**	6/27/2019	
13							
14				**Facility (f)**			
15	**fMR-1:**	Type of Medical Records?		Paper			
16	~~**fMR-2:**~~	~~Name of Electronic Health Record?~~				~~N/A~~	
17							
18							
19	**Total Applicable:**		10	10	10	10	10
20	**Total Met:**		10	10	10	10	10
21	**% Compliance:**	100%	100%	100%	100%	100%	100%
22							
23	**Patient(s)**	**A# (numbers only)**	**Identifying information:** Detainee name, ID number, date of birth, gender.	**Current problem list:** Medical and mental health diagnoses and treatments; known allergies.	**Receiving screen and health assessment forms**	**Progress notes:** For all encounters, with documentation of significant findings, diagnoses, treatments, and dispositions, preferably SOAP format.	**Clinician orders for medication are signed**
24	1	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
25	2	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
26	3	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
27	4	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
28	5	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
29	6	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
30	7	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
31	8	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
32	9	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant
33	10	b(6), b(7)(c)	Compliant	Compliant	Compliant	Compliant	Compliant

AMERICAN OVERSIGHT

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7	mple, if most of the ’
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21	100%
22	
23	**MARs:** Placed in record within 2 weeks of previous month
24	Compliant
25	Compliant
26	Compliant
27	Compliant
28	Compliant
29	Compliant
30	Compliant
31	Compliant
32	Compliant
33	Compliant

AMERICAN OVERSIGHT

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19	0	4	10	10	0	0	0	0
20	0	4	10	10	0	0	0	0
21		100%	100%	100%				
22								
23	**Lab and diagnostic reports:** Acknowledged and dated.	**Flowsheets**	**Consents for medical care and treatment**	**Signed refusals of care**	**Results of specialty consultations and referrals:** Acknowledged and dated.	**Discharge summaries from ED and hospitalizations**	**Special needs treatment plan, where applicable**	**Immunization records, where applicable**
24	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
25	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A
26	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A
27	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A
28	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
29	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
30	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
31	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
32	N/A	N/A	Compliant	Compliant	N/A	N/A	N/A	N/A
33	N/A	Compliant	Compliant	Compliant	N/A	N/A	N/A	N/A

AMERICAN OVERSIGHT

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18							
19	10	10	10	10	10	0	0
20	10	10	10	10	10	0	0
21	100%	100%	100%	100%	100%		
22							
23	**Date and time of each encounter**	**Integrated medical, dental and mental health record**	**Timely filing, within 72 hours**	**Consolidated medical record:** Records from prior stays incorporated.	**Content organized for easy retrieval of outside records, pertinent diagnostics, and consultations**	**EHR password protected**	**Integrated health information with EHR, where applicable:** Incorporation of information that arrives on paper into the EHR.
24	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
25	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
26	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
27	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
28	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
29	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
30	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
31	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
32	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A
33	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1			**MENTAL HEALTH SCREEN**						
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		5						
3				10					
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for mental health evaluation.							
5	**Source:**	Intake screens of detainees, mental health referral logs, mental health caseload.							
6	**Sample:**	10 randomly selected intake screens with positive mental health screens, if available.							
7	**Guidelines:**								
8									
9	**Remarks:**	~~POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.~~							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
12									
13			**Clinical (c)**						
14	**cMHS-1**	Are detainees with positive screens for mental illness evaluated by mental health professionals in a timely manner (emergent = immediately; urgent = within 24 hours; routine = within 7 days)? *14 days for stable patients. Unstable patients or those on multiple medications (4 or more) should be seen sooner.							
15									
16	**Total Applicable:**		5						
17	**Total Met:**		5						
18	**% Compliance:**	100%	100%						
19									
20	**Patient(s)**	**A# (numbers only)**	**cMHS-1**						
21	1	b(6), b(7)(c)	Yes						
22	2	b(6), b(7)(c)	Yes						
23	3	b(6), b(7)(c)	Yes						
24	4	b(6), b(7)(c)	Yes						
25	5	b(6), b(7)(c)	Yes						
26	6		Select						
27	7		Select						
28	8		Select						
29	9		Select						
30	10		Select						

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1				MENTAL HEALTH TREATMENT PLANNING					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		4						
3				10					
4	**Purpose:**	To conform with detention standards for mental health intervention, consistent with nationally-accepted clinical guidelines (NCCHC).							
5	**Source:**	Patients on mental health caseload, including all patients on psychotropic medication.							
6	**Sample:**	10 patients selected from mental health caseload log or MARs, currently or recently in custody, if available.							
7	**Guidelines:**	NCCHC 2014 J-G-04 (Item 2)							
8									
9	**Remarks:**	~~POLICIES REVIEWED: Policy E-05 (Important) "Mental Health Screening and Evaluation (MH Services Provided)" is compliant with PBNDS 2008.~~							
10									
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		6/27/2019		
12									
13				**Clinical (c)**					
14	**cMHT-1**	Is a clinical assessment, treatment, and follow-up plan documented?							
15	**cMHT-2**	Are treatment plans updated at a minimum of every 90 days?							
16									
17	**Total Applicable:**		4	4					
18	**Total Met:**		4	4					
19	**% Compliance:**	100%	100%	100%					
20									
21	**Patient(s)**	**A# (numbers only)**	**cMHT-1**	**cMHT-2**					
22	1	b(6), b(7)(c)	Yes	Yes					
23	2	b(6), b(7)(c)	Yes	Yes					
24	3	b(6), b(7)(c)	Yes	Yes					
25	4	b(6), b(7)(c)	Yes	Yes					
26	5		Select	Select					
27	6		Select	Select					
28	7		Select	Select					
29	8		Select	Select					
30	9		Select	Select					
31	10		Select	Select					

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**PREGNANT WOMEN**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To determine compliance with detention standards and continuity and coordination of care.						
5	**Source:**	Current census of pregnant detainees or pregnant detainees in custody in the last 6 months.						
6	**Sample:**	10 pregnant detainees, if available.						
7	**Guidelines:**	NCCHC 2014 J-G-09; ACA 2004 4-ALDF-4C-13.						
8								
9	**Remarks:**			Type Text Here				
10								
11	**Reviewer:**	Type Text Here			**Date Reviewed:**		Select	
12								
13				**Facility (f)**				
14	**fPG-1:**	Does the facility perform a pregnancy test on females aged 10 to 56 during				N/A		
15		intake screening?						
16								
17				**Clinical (c)**				
18	**cPG-1**	Was a pregnancy test performed prior to x-ray or before initiation of any medications?						
19	**cPG-2**	Was an OB/GYN consult ordered for each pregnant patient with 7 days of pregnancy confirmation?						
20	**cPG-3**	Was the pregnant patient seen by OB/GYN within 30 days of pregnancy confirmation?						
21	**cPG-4**	Was the pregnant patient screened for HIV, STI and viral hepatitis?						
22	**cPG-5**	Were prenatal vitamins prescribed?						
23								
24	**Total Applicable:**		0	0	0	0	0	
25	**Total Met:**		0	0	0	0	0	
26	**% Compliance:**							
27								
28	**Patient(s)**	**A# (numbers only)**	**cPG-1**	**cPG-2**	**cPG-3**	**cPG-4**	**cPG-5**	
29	1		Select	Select	Select	Select	Select	
30	2		Select	Select	Select	Select	Select	
31	3		Select	Select	Select	Select	Select	
32	4		Select	Select	Select	Select	Select	
33	5		Select	Select	Select	Select	Select	
34	6		Select	Select	Select	Select	Select	
35	7		Select	Select	Select	Select	Select	
36	8		Select	Select	Select	Select	Select	
37	9		Select	Select	Select	Select	Select	
38	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1				**SUICIDE SCREENING**				
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To assess conformance with nationally-accepted guidelines for suicide risk assessment and prevention.						
5	**Source:**	Patients on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
6	**Sample:**	Medical records for 10 patients (if available) placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review.						
7	**Guidelines:**	NCCHC 2014 J-G-05; ACA 2004 4-ALDF-4C-32						
8								
9	**Remarks:**	~~POLICIES REVIEWED: Policy G-05 (Essential) "Suicide Prevention Program" is complaint with PBNS 2008. No charts available for review. Housed offsite.~~						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		Select	
12								
13				**Facility (f)**				
14	**fSS-1:**	What is the total number of patients placed on suicide watch or hospitalized for suicidality within the last 3 months or since the most recent review?					25	
15	**fSS-2:**	Does the facility use an acceptable suicide risk management screening instrument, including at a minimum, asking for a history of suicide attempts and for current suicidal ideation?					Y	
16	**fSS-3:**	Are all screeners and all staff in direct contact with detainees trained to assess suicide risk (see training logs)?					Y	
17								
18				**Clinical (c)**				
19	**cSS-1**	What type of monitoring was practiced while the patient was on suicide watch?						
20	**cSS-2**	Were checks documented consistently?						
21	**cSS-3**	Was the suicidal patient evaluated by a mental health professional within 24 hours of identification?						
22	**cSS-4**	Was the patient evaluated by a qualified mental health professional daily while on suicide watch?						
23	**cSS-5**	Is there evidence that earlier intervention might have prevented deterioration to the point of need for a suicide watch? If yes, please describe in the remarks section.						
24								
25	**Total Applicable:**			0	0	0	0	
26	**Total Met:**			0	0	0	0	
27	**% Compliance:**							
28								
29	**Patient(s)**	**A# (numbers only)**	**cSS-1**	**cSS-2**	**cSS-3**	**cSS-4**	**cSS-5**	
30	1		Select	Select	Select	Select	Select	
31	2		Select	Select	Select	Select	Select	
32	3		Select	Select	Select	Select	Select	
33	4		Select	Select	Select	Select	Select	
34	5		Select	Select	Select	Select	Select	
35	6		Select	Select	Select	Select	Select	
36	7		Select	Select	Select	Select	Select	
37	8		Select	Select	Select	Select	Select	
38	9		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
39	10		Select	Select	Select	Select	Select	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**TREATMENT OF DISABILITY**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** **(please select 0 if no files/patients reviewed)**		0					
3				10				
4	**Purpose:**	To assess the care of patients with disabilities who need accommodations to access the facility's programs or activities as a result of their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment. See also: https://www.dhs.gov/sites/default/files/publications/guide-interacting-with-people-who-have-disabilties_09-26-13.pdf						
5	**Source:**	Facility logs, tour of facility, list of patients who require DME (to include walkers, canes, wheel chairs, hearing aids, or other items to assist the patients to access the facility's programs and activities), and interviews with patients with disabilities who need accommodations to access the facility's programs and activities.						
6	**Sample:**	10 patients (if available) within the population who have a disability that requires medical involvement. Determine if the patients with disabilities received appropriate treatment and disability accommodations through medical record examination.						
7	**Guidelines:**	NCCHC J-G-02.						
8								
9	**Remarks:**	~~POLICIES REVIEWED: POLICY G-02 (Essential) "Patients with Special Health Needs";Policy G-10 "Aids to Impairment" is~~ compliant with PBNDS 2008. No charts available for review. Housed off site.						
10								
11	**Reviewer:**	b(6), b(7)(c)			**Date Reviewed:**		Select	
12								
13			**Facility (f)**					
14	**fTD-1:**	Does the facility maintain a current list of all patients with disabilities on site?					Select	
15								
16			**Clinical (c)**					
17	**cTD-1**	Is the disability prominently noted in the file, along with any needed accommodations?						
18	**cTD-2**	Was the patient assessed for assistance with activities of daily living (ADL) upon identification of disability?						
19	**cTD-3**	Were appropriate accommodation orders entered (e.g., lower bunk, mobility device (wheelchair, walker, canes, crutches), hearing aid, assistive listening device, sign language interpreter, meal, etc.)?						
20	**cTD-4**	Was ADL assistance provided, if applicable?						
21								
22	**Total Applicable:**		0	0	0	0		
23	**Total Met:**		0	0	0	0		
24	**% Compliance:**							
25								
26	**Patient(s)**	**A# (numbers only)**	**cTD-1**	**cTD-2**	**cTD-3**	**cTD-4**		
27	1		Select	Select	Select	Select		
28	2		Select	Select	Select	Select		
29	3		Select	Select	Select	Select		
30	4		Select	Select	Select	Select		
31	5		Select	Select	Select	Select		
32	6		Select	Select	Select	Select		
33	7		Select	Select	Select	Select		
34	8		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
35	9		Select	Select	Select	Select		
36	10		Select	Select	Select	Select		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1			**URGENT CARE (SICK CALL)**					
2	**Number of Files Reviewed for Patients Meeting this Criteria:*** (please select 0 if no files/patients reviewed)		10	Add Sample Rows		Reset Sample Rows		
3				10				
4	**Purpose:**	To assess for timely and appropriate nursing care for acute conditions.						
5	**Source:**	Urgent care log, sick call request list, or sick call visit list, preferably with reason for visit noted on log.						
6	**Sample:**	10 urgent care visits for detainees with potentially serious complaints that occurred 1 to 3 weeks prior to review, if available. Common potentially serious con include chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, etc.						
7	**Guidelines:**	NCCHC 2014 J-A-01, J-E-07; ACA 2004 4-ALDF-4C-03, 4-ALDF-4D-03.						
8		POLICIES REVIEWED: Policy E-07 (essential) "Non-Emergency Health Care Requests and Services" is compliant with PBNDS 2008.						-8 of 10 (
9	**Remarks:**	timely and appropriate evaluation by nursing staff (seen within 72 hours). The detainees requesting sick call via the tablet were triaged in 48 hours vs within						
10			like the detainees who requested sick call via paper.					
11	**Reviewer:**		b(6), b(7)(c)			**Date Reviewed:**		6/27/20
12								
13			**Clinical (c)**					
14	**cUC-1**	Was there timely and appropriate evaluation by nursing staff, depending on the nature of the complaint?						
15	**cUC-2**	Was care delivered within the scope of the nurse's license?						
16	**cUC-3**	Were vital signs documented during the nurse's assessment?						
17	**cUC-4**	If necessary, was a nursing referral to an MD/PA/NP/DMD submitted within 24 hours where appropriate?						
18	**cUC-5**	If referred, was an MD/PA/NP/DMD assessment and plan documented?						
19								
20	**Total Applicable:**			10	10	10	2	0
21	**Total Met:**			8	10	10	2	0
22	**% Compliance:**	95%		80%	100%	100%	100%	
23								
24	**Patient(s)**	**A# (numbers only)**	**Chief Complaint**	**cUC-1**	**cUC-2**	**cUC-3**	**cUC-4**	**cUC-5**
25	1	b(6), b(7)(c)	request snacks d/t being diabetic	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
26	2	b(6), b(7)(c)	sore throat	No	Yes	Yes	N/A - NLOS	N/A - NLOS
27	3	b(6), b(7)(c)	dandruff	No	Yes	Yes	N/A - NLOS	N/A - NLOS
28	4	b(6), b(7)(c)	athlete's foot	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
29	5	b(6), b(7)(c)	dental pain	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
30	6	b(6), b(7)(c)	scabies	Yes	Yes	Yes	Yes	N/A - NLOS
31	7	b(6), b(7)(c)	sore throat	Yes	Yes	Yes	Yes	N/A - NLOS
32	8	b(6), b(7)(c)	dermatitis	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
33	9	b(6), b(7)(c)	sore throat	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS
34	10	b(6), b(7)(c)	upper respiratory infection	Yes	Yes	Yes	N/A - NLOS	N/A - NLOS

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1											
2			**Dates**	**States**							
3	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select
4	Yes	Yes	12/1/2017	AL	Recent Lab	Y	Cardiology	Medical	Paper	Compliant	Constant (1:1)
5	No	No	12/2/2017	AK	Patient Interview	N	Endocrinology	Commissary	Electronic	Partial Compliance	Constant (camera)
6	N/A	N/A - LOS	12/3/2017	AZ	Medical Record		Gastroenterology	Both	Both	Non-Compliant	At least q 15 min
7		N/A - NLOS	12/4/2017	AR			General Surgery			N/A	Less often
8			12/5/2017	CA			Hematology				
9			12/6/2017	CO			Infectious Disease				
10			12/7/2017	CT			Neurology				
11			12/8/2017	DE			OB/Gyn				
12			12/9/2017	FL			Oncology				
13			12/10/2017	GA			Opthalmology				
14			12/11/2017	HI			Orthopedics				
15			12/12/2017	ID			Psychiatry				
16			12/13/2017	IL			Pulmonology				
17			12/14/2017	IN			Rheumatology				
18			12/15/2017	IA			Other				
19			12/16/2017	KS							
20			12/17/2017	KY							
21			12/18/2017	LA							
22			12/19/2017	ME							
23			12/20/2017	MD							
24			12/21/2017	MA							
25			12/22/2017	MI							
26			12/23/2017	MN							
27			12/24/2017	MS							
28			12/25/2017	MO							
29			12/26/2017	MT							
30			12/27/2017	NE							
31			12/28/2017	NV							
32			12/29/2017	NH							
33			12/30/2017	NJ							
34			12/31/2017	NM							
35			1/1/2018	NY							
36			1/2/2018	NC							
37			1/3/2018	ND							
38			1/4/2018	OH							
39			1/5/2018	OK							
40			1/6/2018	OR							
41			1/7/2018	PA							
42			1/8/2018	RI							
43			1/9/2018	SC							
44			1/10/2018	SD							
45			1/11/2018	TN							
46			1/12/2018	TX							

AMERICAN OVERSIGHT

	L	M	N
1			
2		**Organization**	**AOR**
3	Select	Select	Select
4	0	IHSC	ATL
5	1	Other	BAL
6	2		BOS
7	3		BUF
8	4		CHI
9	5		DAL
10	6		DEN
11	7		DET
12	8		ELP
13	9		HOU
14	10		LOS
15	11		MIA
16	12		NEW
17	13		NOL
18	14		NYC
19	15		PHI
20	16		PHO
21	17		SEA
22	18		SFR
23	19		SLC
24	20		SNA
25	21		SND
26	22		SPM
27	23		WAS
28	24		COW
29	25		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
47			1/13/2018	UT							
48			1/14/2018	VT							
49			1/15/2018	VA							
50			1/16/2018	WA							
51			1/17/2018	WV							
52			1/18/2018	WI							
53			1/19/2018	WY							
54			1/20/2018								
55			1/21/2018								
56			1/22/2018								
57			1/23/2018								
58			1/24/2018								
59			1/25/2018								
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61			1/27/2018								
62			1/28/2018								
63			1/29/2018								
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65			1/31/2018								
66			2/1/2018								
67			2/2/2018								
68			2/3/2018								
69			2/4/2018								
70			2/5/2018								
71			2/6/2018								
72			2/7/2018								
73			2/8/2018								
74			2/9/2018								
75			2/10/2018								
76			2/11/2018								
77			2/12/2018								
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90			2/25/2018								
91			2/26/2018								
92			2/27/2018								

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
93			2/28/2018								
94			3/1/2018								
95			3/2/2018								
96			3/3/2018								
97			3/4/2018								
98			3/5/2018								
99			3/6/2018								
100			3/7/2018								
101			3/8/2018								
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125			4/1/2018								
126			4/2/2018								
127			4/3/2018								
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129			4/5/2018								
130			4/6/2018								
131			4/7/2018								
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134			4/10/2018								
135			4/11/2018								
136			4/12/2018								
137			4/13/2018								
138			4/14/2018								

AMERICAN OVERSIGHT

	L	M	N
93	89		
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101	97		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
139			4/15/2018								
140			4/16/2018								
141			4/17/2018								
142			4/18/2018								
143			4/19/2018								
144			4/20/2018								
145			4/21/2018								
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147			4/23/2018								
148			4/24/2018								
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150			4/26/2018								
151			4/27/2018								
152			4/28/2018								
153			4/29/2018								
154			4/30/2018								
155			5/1/2018								
156			5/2/2018								
157			5/3/2018								
158			5/4/2018								
159			5/5/2018								
160			5/6/2018								
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182			5/28/2018								
183			5/29/2018								
184			5/30/2018								

AMERICAN OVERSIGHT

	L	M	N
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147	143		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
185			5/31/2018								
186			6/1/2018								
187			6/2/2018								
188			6/3/2018								
189			6/4/2018								
190			6/5/2018								
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192			6/7/2018								
193			6/8/2018								
194			6/9/2018								
195			6/10/2018								
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198			6/13/2018								
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201			6/16/2018								
202			6/17/2018								
203			6/18/2018								
204			6/19/2018								
205			6/20/2018								
206			6/21/2018								
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216			7/1/2018								
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229			7/14/2018								
230			7/15/2018								

AMERICAN OVERSIGHT

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185	181		
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228	224		
229	225		
230	226		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
231			7/16/2018								
232			7/17/2018								
233			7/18/2018								
234			7/19/2018								
235			7/20/2018								
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245			7/30/2018								
246			7/31/2018								
247			8/1/2018								
248			8/2/2018								
249			8/3/2018								
250			8/4/2018								
251			8/5/2018								
252			8/6/2018								
253			8/7/2018								
254			8/8/2018								
255			8/9/2018								
256			8/10/2018								
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261			8/15/2018								
262			8/16/2018								
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267			8/21/2018								
268			8/22/2018								
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273			8/27/2018								
274			8/28/2018								
275			8/29/2018								
276			8/30/2018								

AMERICAN OVERSIGHT

	L	M	N
231	227		
232	228		
233	229		
234	230		
235	231		
236	232		
237	233		
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272	268		
273	269		
274	270		
275	271		
276	272		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
277			8/31/2018								
278			9/1/2018								
279			9/2/2018								
280			9/3/2018								
281			9/4/2018								
282			9/5/2018								
283			9/6/2018								
284			9/7/2018								
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287			9/10/2018								
288			9/11/2018								
289			9/12/2018								
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291			9/14/2018								
292			9/15/2018								
293			9/16/2018								
294			9/17/2018								
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298			9/21/2018								
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306			9/29/2018								
307			9/30/2018								
308			10/1/2018								
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310			10/3/2018								
311			10/4/2018								
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313			10/6/2018								
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316			10/9/2018								
317			10/10/2018								
318			10/11/2018								
319			10/12/2018								
320			10/13/2018								
321			10/14/2018								
322			10/15/2018								

AMERICAN OVERSIGHT

	L	M	N
277	273		
278	274		
279	275		
280	276		
281	277		
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284	280		
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321	317		
322	318		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
323			10/16/2018								
324			10/17/2018								
325			10/18/2018								
326			10/19/2018								
327			10/20/2018								
328			10/21/2018								
329			10/22/2018								
330			10/23/2018								
331			10/24/2018								
332			10/25/2018								
333			10/26/2018								
334			10/27/2018								
335			10/28/2018								
336			10/29/2018								
337			10/30/2018								
338			10/31/2018								
339			11/1/2018								
340			11/2/2018								
341			11/3/2018								
342			11/4/2018								
343			11/5/2018								
344			11/6/2018								
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349			11/11/2018								
350			11/12/2018								
351			11/13/2018								
352			11/14/2018								
353			11/15/2018								
354			11/16/2018								
355			11/17/2018								
356			11/18/2018								
357			11/19/2018								
358			11/20/2018								
359			11/21/2018								
360			11/22/2018								
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363			11/25/2018								
364			11/26/2018								
365			11/27/2018								
366			11/28/2018								
367			11/29/2018								
368			11/30/2018								

AMERICAN OVERSIGHT

	L	M	N
323	319		
324	320		
325	321		
326	322		
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329	325		
330	326		
331	327		
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368	364		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
369			12/1/2018								
370			12/2/2018								
371			12/3/2018								
372			12/4/2018								
373			12/5/2018								
374			12/6/2018								
375			12/7/2018								
376			12/8/2018								
377			12/9/2018								
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379			12/11/2018								
380			12/12/2018								
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384			12/16/2018								
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389			12/21/2018								
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392			12/24/2018								
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394			12/26/2018								
395			12/27/2018								
396			12/28/2018								
397			12/29/2018								
398			12/30/2018								
399			12/31/2018								
400			1/1/2019								
401			1/2/2019								
402			1/3/2019								
403			1/4/2019								
404			1/5/2019								
405			1/6/2019								
406			1/7/2019								
407			1/8/2019								
408			1/9/2019								
409			1/10/2019								
410			1/11/2019								
411			1/12/2019								
412			1/13/2019								
413			1/14/2019								
414			1/15/2019								

AMERICAN OVERSIGHT

	L	M	N
369	365		
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413	409		
414	410		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
415			1/16/2019								
416			1/17/2019								
417			1/18/2019								
418			1/19/2019								
419			1/20/2019								
420			1/21/2019								
421			1/22/2019								
422			1/23/2019								
423			1/24/2019								
424			1/25/2019								
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426			1/27/2019								
427			1/28/2019								
428			1/29/2019								
429			1/30/2019								
430			1/31/2019								
431			2/1/2019								
432			2/2/2019								
433			2/3/2019								
434			2/4/2019								
435			2/5/2019								
436			2/6/2019								
437			2/7/2019								
438			2/8/2019								
439			2/9/2019								
440			2/10/2019								
441			2/11/2019								
442			2/12/2019								
443			2/13/2019								
444			2/14/2019								
445			2/15/2019								
446			2/16/2019								
447			2/17/2019								
448			2/18/2019								
449			2/19/2019								
450			2/20/2019								
451			2/21/2019								
452			2/22/2019								
453			2/23/2019								
454			2/24/2019								
455			2/25/2019								
456			2/26/2019								
457			2/27/2019								
458			2/28/2019								
459			3/1/2019								
460			3/2/2019								

AMERICAN OVERSIGHT

	L	M	N
415	411		
416	412		
417	413		
418	414		
419	415		
420	416		
421	417		
422	418		
423	419		
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459	455		
460	456		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
461			3/3/2019								
462			3/4/2019								
463			3/5/2019								
464			3/6/2019								
465			3/7/2019								
466			3/8/2019								
467			3/9/2019								
468			3/10/2019								
469			3/11/2019								
470			3/12/2019								
471			3/13/2019								
472			3/14/2019								
473			3/15/2019								
474			3/16/2019								
475			3/17/2019								
476			3/18/2019								
477			3/19/2019								
478			3/20/2019								
479			3/21/2019								
480			3/22/2019								
481			3/23/2019								
482			3/24/2019								
483			3/25/2019								
484			3/26/2019								
485			3/27/2019								
486			3/28/2019								
487			3/29/2019								
488			3/30/2019								
489			3/31/2019								
490			4/1/2019								
491			4/2/2019								
492			4/3/2019								
493			4/4/2019								
494			4/5/2019								
495			4/6/2019								
496			4/7/2019								
497			4/8/2019								
498			4/9/2019								
499			4/10/2019								
500			4/11/2019								
501			4/12/2019								
502			4/13/2019								
503			4/14/2019								
504			4/15/2019								
505			4/16/2019								
506			4/17/2019								

AMERICAN OVERSIGHT

	L	M	N
461	457		
462	458		
463	459		
464	460		
465	461		
466	462		
467	463		
468	464		
469	465		
470	466		
471	467		
472	468		
473	469		
474	470		
475	471		
476	472		
477	473		
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504	500		
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
507			4/18/2019								
508			4/19/2019								
509			4/20/2019								
510			4/21/2019								
511			4/22/2019								
512			4/23/2019								
513			4/24/2019								
514			4/25/2019								
515			4/26/2019								
516			4/27/2019								
517			4/28/2019								
518			4/29/2019								
519			4/30/2019								
520			5/1/2019								
521			5/2/2019								
522			5/3/2019								
523			5/4/2019								
524			5/5/2019								
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528			5/9/2019								
529			5/10/2019								
530			5/11/2019								
531			5/12/2019								
532			5/13/2019								
533			5/14/2019								
534			5/15/2019								
535			5/16/2019								
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537			5/18/2019								
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542			5/23/2019								
543			5/24/2019								
544			5/25/2019								
545			5/26/2019								
546			5/27/2019								
547			5/28/2019								
548			5/29/2019								
549			5/30/2019								
550			5/31/2019								
551			6/1/2019								
552			6/2/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
553			6/3/2019								
554			6/4/2019								
555			6/5/2019								
556			6/6/2019								
557			6/7/2019								
558			6/8/2019								
559			6/9/2019								
560			6/10/2019								
561			6/11/2019								
562			6/12/2019								
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567			6/17/2019								
568			6/18/2019								
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571			6/21/2019								
572			6/22/2019								
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574			6/24/2019								
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576			6/26/2019								
577			6/27/2019								
578			6/28/2019								
579			6/29/2019								
580			6/30/2019								
581			7/1/2019								
582			7/2/2019								
583			7/3/2019								
584			7/4/2019								
585			7/5/2019								
586			7/6/2019								
587			7/7/2019								
588			7/8/2019								
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591			7/11/2019								
592			7/12/2019								
593			7/13/2019								
594			7/14/2019								
595			7/15/2019								
596			7/16/2019								
597			7/17/2019								
598			7/18/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
599			7/19/2019								
600			7/20/2019								
601			7/21/2019								
602			7/22/2019								
603			7/23/2019								
604			7/24/2019								
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611			7/31/2019								
612			8/1/2019								
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618			8/7/2019								
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622			8/11/2019								
623			8/12/2019								
624			8/13/2019								
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639			8/28/2019								
640			8/29/2019								
641			8/30/2019								
642			8/31/2019								
643			9/1/2019								
644			9/2/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
645			9/3/2019								
646			9/4/2019								
647			9/5/2019								
648			9/6/2019								
649			9/7/2019								
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651			9/9/2019								
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671			9/29/2019								
672			9/30/2019								
673			10/1/2019								
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683			10/11/2019								
684			10/12/2019								
685			10/13/2019								
686			10/14/2019								
687			10/15/2019								
688			10/16/2019								
689			10/17/2019								
690			10/18/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
691			10/19/2019								
692			10/20/2019								
693			10/21/2019								
694			10/22/2019								
695			10/23/2019								
696			10/24/2019								
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698			10/26/2019								
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703			10/31/2019								
704			11/1/2019								
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718			11/15/2019								
719			11/16/2019								
720			11/17/2019								
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722			11/19/2019								
723			11/20/2019								
724			11/21/2019								
725			11/22/2019								
726			11/23/2019								
727			11/24/2019								
728			11/25/2019								
729			11/26/2019								
730			11/27/2019								
731			11/28/2019								
732			11/29/2019								
733			11/30/2019								
734			12/1/2019								
735			12/2/2019								
736			12/3/2019								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
737			12/4/2019								
738			12/5/2019								
739			12/6/2019								
740			12/7/2019								
741			12/8/2019								
742			12/9/2019								
743			12/10/2019								
744			12/11/2019								
745			12/12/2019								
746			12/13/2019								
747			12/14/2019								
748			12/15/2019								
749			12/16/2019								
750			12/17/2019								
751			12/18/2019								
752			12/19/2019								
753			12/20/2019								
754			12/21/2019								
755			12/22/2019								
756			12/23/2019								
757			12/24/2019								
758			12/25/2019								
759			12/26/2019								
760			12/27/2019								
761			12/28/2019								
762			12/29/2019								
763			12/30/2019								
764			12/31/2019								
765			1/1/2020								
766			1/2/2020								
767			1/3/2020								
768			1/4/2020								
769			1/5/2020								
770			1/6/2020								
771			1/7/2020								
772			1/8/2020								
773			1/9/2020								
774			1/10/2020								
775			1/11/2020								
776			1/12/2020								
777			1/13/2020								
778			1/14/2020								
779			1/15/2020								
780			1/16/2020								
781			1/17/2020								
782			1/18/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
783			1/19/2020								
784			1/20/2020								
785			1/21/2020								
786			1/22/2020								
787			1/23/2020								
788			1/24/2020								
789			1/25/2020								
790			1/26/2020								
791			1/27/2020								
792			1/28/2020								
793			1/29/2020								
794			1/30/2020								
795			1/31/2020								
796			2/1/2020								
797			2/2/2020								
798			2/3/2020								
799			2/4/2020								
800			2/5/2020								
801			2/6/2020								
802			2/7/2020								
803			2/8/2020								
804			2/9/2020								
805			2/10/2020								
806			2/11/2020								
807			2/12/2020								
808			2/13/2020								
809			2/14/2020								
810			2/15/2020								
811			2/16/2020								
812			2/17/2020								
813			2/18/2020								
814			2/19/2020								
815			2/20/2020								
816			2/21/2020								
817			2/22/2020								
818			2/23/2020								
819			2/24/2020								
820			2/25/2020								
821			2/26/2020								
822			2/27/2020								
823			2/28/2020								
824			2/29/2020								
825			3/1/2020								
826			3/2/2020								
827			3/3/2020								
828			3/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
829			3/5/2020								
830			3/6/2020								
831			3/7/2020								
832			3/8/2020								
833			3/9/2020								
834			3/10/2020								
835			3/11/2020								
836			3/12/2020								
837			3/13/2020								
838			3/14/2020								
839			3/15/2020								
840			3/16/2020								
841			3/17/2020								
842			3/18/2020								
843			3/19/2020								
844			3/20/2020								
845			3/21/2020								
846			3/22/2020								
847			3/23/2020								
848			3/24/2020								
849			3/25/2020								
850			3/26/2020								
851			3/27/2020								
852			3/28/2020								
853			3/29/2020								
854			3/30/2020								
855			3/31/2020								
856			4/1/2020								
857			4/2/2020								
858			4/3/2020								
859			4/4/2020								
860			4/5/2020								
861			4/6/2020								
862			4/7/2020								
863			4/8/2020								
864			4/9/2020								
865			4/10/2020								
866			4/11/2020								
867			4/12/2020								
868			4/13/2020								
869			4/14/2020								
870			4/15/2020								
871			4/16/2020								
872			4/17/2020								
873			4/18/2020								
874			4/19/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
875			4/20/2020								
876			4/21/2020								
877			4/22/2020								
878			4/23/2020								
879			4/24/2020								
880			4/25/2020								
881			4/26/2020								
882			4/27/2020								
883			4/28/2020								
884			4/29/2020								
885			4/30/2020								
886			5/1/2020								
887			5/2/2020								
888			5/3/2020								
889			5/4/2020								
890			5/5/2020								
891			5/6/2020								
892			5/7/2020								
893			5/8/2020								
894			5/9/2020								
895			5/10/2020								
896			5/11/2020								
897			5/12/2020								
898			5/13/2020								
899			5/14/2020								
900			5/15/2020								
901			5/16/2020								
902			5/17/2020								
903			5/18/2020								
904			5/19/2020								
905			5/20/2020								
906			5/21/2020								
907			5/22/2020								
908			5/23/2020								
909			5/24/2020								
910			5/25/2020								
911			5/26/2020								
912			5/27/2020								
913			5/28/2020								
914			5/29/2020								
915			5/30/2020								
916			5/31/2020								
917			6/1/2020								
918			6/2/2020								
919			6/3/2020								
920			6/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
921			6/5/2020								
922			6/6/2020								
923			6/7/2020								
924			6/8/2020								
925			6/9/2020								
926			6/10/2020								
927			6/11/2020								
928			6/12/2020								
929			6/13/2020								
930			6/14/2020								
931			6/15/2020								
932			6/16/2020								
933			6/17/2020								
934			6/18/2020								
935			6/19/2020								
936			6/20/2020								
937			6/21/2020								
938			6/22/2020								
939			6/23/2020								
940			6/24/2020								
941			6/25/2020								
942			6/26/2020								
943			6/27/2020								
944			6/28/2020								
945			6/29/2020								
946			6/30/2020								
947			7/1/2020								
948			7/2/2020								
949			7/3/2020								
950			7/4/2020								
951			7/5/2020								
952			7/6/2020								
953			7/7/2020								
954			7/8/2020								
955			7/9/2020								
956			7/10/2020								
957			7/11/2020								
958			7/12/2020								
959			7/13/2020								
960			7/14/2020								
961			7/15/2020								
962			7/16/2020								
963			7/17/2020								
964			7/18/2020								
965			7/19/2020								
966			7/20/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
967			7/21/2020								
968			7/22/2020								
969			7/23/2020								
970			7/24/2020								
971			7/25/2020								
972			7/26/2020								
973			7/27/2020								
974			7/28/2020								
975			7/29/2020								
976			7/30/2020								
977			7/31/2020								
978			8/1/2020								
979			8/2/2020								
980			8/3/2020								
981			8/4/2020								
982			8/5/2020								
983			8/6/2020								
984			8/7/2020								
985			8/8/2020								
986			8/9/2020								
987			8/10/2020								
988			8/11/2020								
989			8/12/2020								
990			8/13/2020								
991			8/14/2020								
992			8/15/2020								
993			8/16/2020								
994			8/17/2020								
995			8/18/2020								
996			8/19/2020								
997			8/20/2020								
998			8/21/2020								
999			8/22/2020								
1000			8/23/2020								
1001			8/24/2020								
1002			8/25/2020								
1003			8/26/2020								
1004			8/27/2020								
1005			8/28/2020								
1006			8/29/2020								
1007			8/30/2020								
1008			8/31/2020								
1009			9/1/2020								
1010			9/2/2020								
1011			9/3/2020								
1012			9/4/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1013			9/5/2020								
1014			9/6/2020								
1015			9/7/2020								
1016			9/8/2020								
1017			9/9/2020								
1018			9/10/2020								
1019			9/11/2020								
1020			9/12/2020								
1021			9/13/2020								
1022			9/14/2020								
1023			9/15/2020								
1024			9/16/2020								
1025			9/17/2020								
1026			9/18/2020								
1027			9/19/2020								
1028			9/20/2020								
1029			9/21/2020								
1030			9/22/2020								
1031			9/23/2020								
1032			9/24/2020								
1033			9/25/2020								
1034			9/26/2020								
1035			9/27/2020								
1036			9/28/2020								
1037			9/29/2020								
1038			9/30/2020								
1039			10/1/2020								
1040			10/2/2020								
1041			10/3/2020								
1042			10/4/2020								
1043			10/5/2020								
1044			10/6/2020								
1045			10/7/2020								
1046			10/8/2020								
1047			10/9/2020								
1048			10/10/2020								
1049			10/11/2020								
1050			10/12/2020								
1051			10/13/2020								
1052			10/14/2020								
1053			10/15/2020								
1054			10/16/2020								
1055			10/17/2020								
1056			10/18/2020								
1057			10/19/2020								
1058			10/20/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1059			10/21/2020								
1060			10/22/2020								
1061			10/23/2020								
1062			10/24/2020								
1063			10/25/2020								
1064			10/26/2020								
1065			10/27/2020								
1066			10/28/2020								
1067			10/29/2020								
1068			10/30/2020								
1069			10/31/2020								
1070			11/1/2020								
1071			11/2/2020								
1072			11/3/2020								
1073			11/4/2020								
1074			11/5/2020								
1075			11/6/2020								
1076			11/7/2020								
1077			11/8/2020								
1078			11/9/2020								
1079			11/10/2020								
1080			11/11/2020								
1081			11/12/2020								
1082			11/13/2020								
1083			11/14/2020								
1084			11/15/2020								
1085			11/16/2020								
1086			11/17/2020								
1087			11/18/2020								
1088			11/19/2020								
1089			11/20/2020								
1090			11/21/2020								
1091			11/22/2020								
1092			11/23/2020								
1093			11/24/2020								
1094			11/25/2020								
1095			11/26/2020								
1096			11/27/2020								
1097			11/28/2020								
1098			11/29/2020								
1099			11/30/2020								
1100			12/1/2020								
1101			12/2/2020								
1102			12/3/2020								
1103			12/4/2020								
1104			12/5/2020								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1105			12/6/2020								
1106			12/7/2020								
1107			12/8/2020								
1108			12/9/2020								
1109			12/10/2020								
1110			12/11/2020								
1111			12/12/2020								
1112			12/13/2020								
1113			12/14/2020								
1114			12/15/2020								
1115			12/16/2020								
1116			12/17/2020								
1117			12/18/2020								
1118			12/19/2020								
1119			12/20/2020								
1120			12/21/2020								
1121			12/22/2020								
1122			12/23/2020								
1123			12/24/2020								
1124			12/25/2020								
1125			12/26/2020								
1126			12/27/2020								
1127			12/28/2020								
1128			12/29/2020								
1129			12/30/2020								
1130			12/31/2020								
1131			1/1/2021								
1132			1/2/2021								
1133			1/3/2021								
1134			1/4/2021								
1135			1/5/2021								
1136			1/6/2021								
1137			1/7/2021								
1138			1/8/2021								
1139			1/9/2021								
1140			1/10/2021								
1141			1/11/2021								
1142			1/12/2021								
1143			1/13/2021								
1144			1/14/2021								
1145			1/15/2021								
1146			1/16/2021								
1147			1/17/2021								
1148			1/18/2021								
1149			1/19/2021								
1150			1/20/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1151			1/21/2021								
1152			1/22/2021								
1153			1/23/2021								
1154			1/24/2021								
1155			1/25/2021								
1156			1/26/2021								
1157			1/27/2021								
1158			1/28/2021								
1159			1/29/2021								
1160			1/30/2021								
1161			1/31/2021								
1162			2/1/2021								
1163			2/2/2021								
1164			2/3/2021								
1165			2/4/2021								
1166			2/5/2021								
1167			2/6/2021								
1168			2/7/2021								
1169			2/8/2021								
1170			2/9/2021								
1171			2/10/2021								
1172			2/11/2021								
1173			2/12/2021								
1174			2/13/2021								
1175			2/14/2021								
1176			2/15/2021								
1177			2/16/2021								
1178			2/17/2021								
1179			2/18/2021								
1180			2/19/2021								
1181			2/20/2021								
1182			2/21/2021								
1183			2/22/2021								
1184			2/23/2021								
1185			2/24/2021								
1186			2/25/2021								
1187			2/26/2021								
1188			2/27/2021								
1189			2/28/2021								
1190			3/1/2021								
1191			3/2/2021								
1192			3/3/2021								
1193			3/4/2021								
1194			3/5/2021								
1195			3/6/2021								
1196			3/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1197			3/8/2021								
1198			3/9/2021								
1199			3/10/2021								
1200			3/11/2021								
1201			3/12/2021								
1202			3/13/2021								
1203			3/14/2021								
1204			3/15/2021								
1205			3/16/2021								
1206			3/17/2021								
1207			3/18/2021								
1208			3/19/2021								
1209			3/20/2021								
1210			3/21/2021								
1211			3/22/2021								
1212			3/23/2021								
1213			3/24/2021								
1214			3/25/2021								
1215			3/26/2021								
1216			3/27/2021								
1217			3/28/2021								
1218			3/29/2021								
1219			3/30/2021								
1220			3/31/2021								
1221			4/1/2021								
1222			4/2/2021								
1223			4/3/2021								
1224			4/4/2021								
1225			4/5/2021								
1226			4/6/2021								
1227			4/7/2021								
1228			4/8/2021								
1229			4/9/2021								
1230			4/10/2021								
1231			4/11/2021								
1232			4/12/2021								
1233			4/13/2021								
1234			4/14/2021								
1235			4/15/2021								
1236			4/16/2021								
1237			4/17/2021								
1238			4/18/2021								
1239			4/19/2021								
1240			4/20/2021								
1241			4/21/2021								
1242			4/22/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1243			4/23/2021								
1244			4/24/2021								
1245			4/25/2021								
1246			4/26/2021								
1247			4/27/2021								
1248			4/28/2021								
1249			4/29/2021								
1250			4/30/2021								
1251			5/1/2021								
1252			5/2/2021								
1253			5/3/2021								
1254			5/4/2021								
1255			5/5/2021								
1256			5/6/2021								
1257			5/7/2021								
1258			5/8/2021								
1259			5/9/2021								
1260			5/10/2021								
1261			5/11/2021								
1262			5/12/2021								
1263			5/13/2021								
1264			5/14/2021								
1265			5/15/2021								
1266			5/16/2021								
1267			5/17/2021								
1268			5/18/2021								
1269			5/19/2021								
1270			5/20/2021								
1271			5/21/2021								
1272			5/22/2021								
1273			5/23/2021								
1274			5/24/2021								
1275			5/25/2021								
1276			5/26/2021								
1277			5/27/2021								
1278			5/28/2021								
1279			5/29/2021								
1280			5/30/2021								
1281			5/31/2021								
1282			6/1/2021								
1283			6/2/2021								
1284			6/3/2021								
1285			6/4/2021								
1286			6/5/2021								
1287			6/6/2021								
1288			6/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1289			6/8/2021								
1290			6/9/2021								
1291			6/10/2021								
1292			6/11/2021								
1293			6/12/2021								
1294			6/13/2021								
1295			6/14/2021								
1296			6/15/2021								
1297			6/16/2021								
1298			6/17/2021								
1299			6/18/2021								
1300			6/19/2021								
1301			6/20/2021								
1302			6/21/2021								
1303			6/22/2021								
1304			6/23/2021								
1305			6/24/2021								
1306			6/25/2021								
1307			6/26/2021								
1308			6/27/2021								
1309			6/28/2021								
1310			6/29/2021								
1311			6/30/2021								
1312			7/1/2021								
1313			7/2/2021								
1314			7/3/2021								
1315			7/4/2021								
1316			7/5/2021								
1317			7/6/2021								
1318			7/7/2021								
1319			7/8/2021								
1320			7/9/2021								
1321			7/10/2021								
1322			7/11/2021								
1323			7/12/2021								
1324			7/13/2021								
1325			7/14/2021								
1326			7/15/2021								
1327			7/16/2021								
1328			7/17/2021								
1329			7/18/2021								
1330			7/19/2021								
1331			7/20/2021								
1332			7/21/2021								
1333			7/22/2021								
1334			7/23/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1335			7/24/2021								
1336			7/25/2021								
1337			7/26/2021								
1338			7/27/2021								
1339			7/28/2021								
1340			7/29/2021								
1341			7/30/2021								
1342			7/31/2021								
1343			8/1/2021								
1344			8/2/2021								
1345			8/3/2021								
1346			8/4/2021								
1347			8/5/2021								
1348			8/6/2021								
1349			8/7/2021								
1350			8/8/2021								
1351			8/9/2021								
1352			8/10/2021								
1353			8/11/2021								
1354			8/12/2021								
1355			8/13/2021								
1356			8/14/2021								
1357			8/15/2021								
1358			8/16/2021								
1359			8/17/2021								
1360			8/18/2021								
1361			8/19/2021								
1362			8/20/2021								
1363			8/21/2021								
1364			8/22/2021								
1365			8/23/2021								
1366			8/24/2021								
1367			8/25/2021								
1368			8/26/2021								
1369			8/27/2021								
1370			8/28/2021								
1371			8/29/2021								
1372			8/30/2021								
1373			8/31/2021								
1374			9/1/2021								
1375			9/2/2021								
1376			9/3/2021								
1377			9/4/2021								
1378			9/5/2021								
1379			9/6/2021								
1380			9/7/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1381			9/8/2021								
1382			9/9/2021								
1383			9/10/2021								
1384			9/11/2021								
1385			9/12/2021								
1386			9/13/2021								
1387			9/14/2021								
1388			9/15/2021								
1389			9/16/2021								
1390			9/17/2021								
1391			9/18/2021								
1392			9/19/2021								
1393			9/20/2021								
1394			9/21/2021								
1395			9/22/2021								
1396			9/23/2021								
1397			9/24/2021								
1398			9/25/2021								
1399			9/26/2021								
1400			9/27/2021								
1401			9/28/2021								
1402			9/29/2021								
1403			9/30/2021								
1404			10/1/2021								
1405			10/2/2021								
1406			10/3/2021								
1407			10/4/2021								
1408			10/5/2021								
1409			10/6/2021								
1410			10/7/2021								
1411			10/8/2021								
1412			10/9/2021								
1413			10/10/2021								
1414			10/11/2021								
1415			10/12/2021								
1416			10/13/2021								
1417			10/14/2021								
1418			10/15/2021								
1419			10/16/2021								
1420			10/17/2021								
1421			10/18/2021								
1422			10/19/2021								
1423			10/20/2021								
1424			10/21/2021								
1425			10/22/2021								
1426			10/23/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1427			10/24/2021								
1428			10/25/2021								
1429			10/26/2021								
1430			10/27/2021								
1431			10/28/2021								
1432			10/29/2021								
1433			10/30/2021								
1434			10/31/2021								
1435			11/1/2021								
1436			11/2/2021								
1437			11/3/2021								
1438			11/4/2021								
1439			11/5/2021								
1440			11/6/2021								
1441			11/7/2021								
1442			11/8/2021								
1443			11/9/2021								
1444			11/10/2021								
1445			11/11/2021								
1446			11/12/2021								
1447			11/13/2021								
1448			11/14/2021								
1449			11/15/2021								
1450			11/16/2021								
1451			11/17/2021								
1452			11/18/2021								
1453			11/19/2021								
1454			11/20/2021								
1455			11/21/2021								
1456			11/22/2021								
1457			11/23/2021								
1458			11/24/2021								
1459			11/25/2021								
1460			11/26/2021								
1461			11/27/2021								
1462			11/28/2021								
1463			11/29/2021								
1464			11/30/2021								
1465			12/1/2021								
1466			12/2/2021								
1467			12/3/2021								
1468			12/4/2021								
1469			12/5/2021								
1470			12/6/2021								
1471			12/7/2021								
1472			12/8/2021								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1473			12/9/2021								
1474			12/10/2021								
1475			12/11/2021								
1476			12/12/2021								
1477			12/13/2021								
1478			12/14/2021								
1479			12/15/2021								
1480			12/16/2021								
1481			12/17/2021								
1482			12/18/2021								
1483			12/19/2021								
1484			12/20/2021								
1485			12/21/2021								
1486			12/22/2021								
1487			12/23/2021								
1488			12/24/2021								
1489			12/25/2021								
1490			12/26/2021								
1491			12/27/2021								
1492			12/28/2021								
1493			12/29/2021								
1494			12/30/2021								
1495			12/31/2021								
1496			1/1/2022								
1497			1/2/2022								
1498			1/3/2022								
1499			1/4/2022								
1500			1/5/2022								
1501			1/6/2022								
1502			1/7/2022								
1503			1/8/2022								
1504			1/9/2022								
1505			1/10/2022								
1506			1/11/2022								
1507			1/12/2022								
1508			1/13/2022								
1509			1/14/2022								
1510			1/15/2022								
1511			1/16/2022								
1512			1/17/2022								
1513			1/18/2022								
1514			1/19/2022								
1515			1/20/2022								
1516			1/21/2022								
1517			1/22/2022								
1518			1/23/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1519			1/24/2022								
1520			1/25/2022								
1521			1/26/2022								
1522			1/27/2022								
1523			1/28/2022								
1524			1/29/2022								
1525			1/30/2022								
1526			1/31/2022								
1527			2/1/2022								
1528			2/2/2022								
1529			2/3/2022								
1530			2/4/2022								
1531			2/5/2022								
1532			2/6/2022								
1533			2/7/2022								
1534			2/8/2022								
1535			2/9/2022								
1536			2/10/2022								
1537			2/11/2022								
1538			2/12/2022								
1539			2/13/2022								
1540			2/14/2022								
1541			2/15/2022								
1542			2/16/2022								
1543			2/17/2022								
1544			2/18/2022								
1545			2/19/2022								
1546			2/20/2022								
1547			2/21/2022								
1548			2/22/2022								
1549			2/23/2022								
1550			2/24/2022								
1551			2/25/2022								
1552			2/26/2022								
1553			2/27/2022								
1554			2/28/2022								
1555			3/1/2022								
1556			3/2/2022								
1557			3/3/2022								
1558			3/4/2022								
1559			3/5/2022								
1560			3/6/2022								
1561			3/7/2022								
1562			3/8/2022								
1563			3/9/2022								
1564			3/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1565			3/11/2022								
1566			3/12/2022								
1567			3/13/2022								
1568			3/14/2022								
1569			3/15/2022								
1570			3/16/2022								
1571			3/17/2022								
1572			3/18/2022								
1573			3/19/2022								
1574			3/20/2022								
1575			3/21/2022								
1576			3/22/2022								
1577			3/23/2022								
1578			3/24/2022								
1579			3/25/2022								
1580			3/26/2022								
1581			3/27/2022								
1582			3/28/2022								
1583			3/29/2022								
1584			3/30/2022								
1585			3/31/2022								
1586			4/1/2022								
1587			4/2/2022								
1588			4/3/2022								
1589			4/4/2022								
1590			4/5/2022								
1591			4/6/2022								
1592			4/7/2022								
1593			4/8/2022								
1594			4/9/2022								
1595			4/10/2022								
1596			4/11/2022								
1597			4/12/2022								
1598			4/13/2022								
1599			4/14/2022								
1600			4/15/2022								
1601			4/16/2022								
1602			4/17/2022								
1603			4/18/2022								
1604			4/19/2022								
1605			4/20/2022								
1606			4/21/2022								
1607			4/22/2022								
1608			4/23/2022								
1609			4/24/2022								
1610			4/25/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1611			4/26/2022								
1612			4/27/2022								
1613			4/28/2022								
1614			4/29/2022								
1615			4/30/2022								
1616			5/1/2022								
1617			5/2/2022								
1618			5/3/2022								
1619			5/4/2022								
1620			5/5/2022								
1621			5/6/2022								
1622			5/7/2022								
1623			5/8/2022								
1624			5/9/2022								
1625			5/10/2022								
1626			5/11/2022								
1627			5/12/2022								
1628			5/13/2022								
1629			5/14/2022								
1630			5/15/2022								
1631			5/16/2022								
1632			5/17/2022								
1633			5/18/2022								
1634			5/19/2022								
1635			5/20/2022								
1636			5/21/2022								
1637			5/22/2022								
1638			5/23/2022								
1639			5/24/2022								
1640			5/25/2022								
1641			5/26/2022								
1642			5/27/2022								
1643			5/28/2022								
1644			5/29/2022								
1645			5/30/2022								
1646			5/31/2022								
1647			6/1/2022								
1648			6/2/2022								
1649			6/3/2022								
1650			6/4/2022								
1651			6/5/2022								
1652			6/6/2022								
1653			6/7/2022								
1654			6/8/2022								
1655			6/9/2022								
1656			6/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1657			6/11/2022								
1658			6/12/2022								
1659			6/13/2022								
1660			6/14/2022								
1661			6/15/2022								
1662			6/16/2022								
1663			6/17/2022								
1664			6/18/2022								
1665			6/19/2022								
1666			6/20/2022								
1667			6/21/2022								
1668			6/22/2022								
1669			6/23/2022								
1670			6/24/2022								
1671			6/25/2022								
1672			6/26/2022								
1673			6/27/2022								
1674			6/28/2022								
1675			6/29/2022								
1676			6/30/2022								
1677			7/1/2022								
1678			7/2/2022								
1679			7/3/2022								
1680			7/4/2022								
1681			7/5/2022								
1682			7/6/2022								
1683			7/7/2022								
1684			7/8/2022								
1685			7/9/2022								
1686			7/10/2022								
1687			7/11/2022								
1688			7/12/2022								
1689			7/13/2022								
1690			7/14/2022								
1691			7/15/2022								
1692			7/16/2022								
1693			7/17/2022								
1694			7/18/2022								
1695			7/19/2022								
1696			7/20/2022								
1697			7/21/2022								
1698			7/22/2022								
1699			7/23/2022								
1700			7/24/2022								
1701			7/25/2022								
1702			7/26/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1703			7/27/2022								
1704			7/28/2022								
1705			7/29/2022								
1706			7/30/2022								
1707			7/31/2022								
1708			8/1/2022								
1709			8/2/2022								
1710			8/3/2022								
1711			8/4/2022								
1712			8/5/2022								
1713			8/6/2022								
1714			8/7/2022								
1715			8/8/2022								
1716			8/9/2022								
1717			8/10/2022								
1718			8/11/2022								
1719			8/12/2022								
1720			8/13/2022								
1721			8/14/2022								
1722			8/15/2022								
1723			8/16/2022								
1724			8/17/2022								
1725			8/18/2022								
1726			8/19/2022								
1727			8/20/2022								
1728			8/21/2022								
1729			8/22/2022								
1730			8/23/2022								
1731			8/24/2022								
1732			8/25/2022								
1733			8/26/2022								
1734			8/27/2022								
1735			8/28/2022								
1736			8/29/2022								
1737			8/30/2022								
1738			8/31/2022								
1739			9/1/2022								
1740			9/2/2022								
1741			9/3/2022								
1742			9/4/2022								
1743			9/5/2022								
1744			9/6/2022								
1745			9/7/2022								
1746			9/8/2022								
1747			9/9/2022								
1748			9/10/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1749			9/11/2022								
1750			9/12/2022								
1751			9/13/2022								
1752			9/14/2022								
1753			9/15/2022								
1754			9/16/2022								
1755			9/17/2022								
1756			9/18/2022								
1757			9/19/2022								
1758			9/20/2022								
1759			9/21/2022								
1760			9/22/2022								
1761			9/23/2022								
1762			9/24/2022								
1763			9/25/2022								
1764			9/26/2022								
1765			9/27/2022								
1766			9/28/2022								
1767			9/29/2022								
1768			9/30/2022								
1769			10/1/2022								
1770			10/2/2022								
1771			10/3/2022								
1772			10/4/2022								
1773			10/5/2022								
1774			10/6/2022								
1775			10/7/2022								
1776			10/8/2022								
1777			10/9/2022								
1778			10/10/2022								
1779			10/11/2022								
1780			10/12/2022								
1781			10/13/2022								
1782			10/14/2022								
1783			10/15/2022								
1784			10/16/2022								
1785			10/17/2022								
1786			10/18/2022								
1787			10/19/2022								
1788			10/20/2022								
1789			10/21/2022								
1790			10/22/2022								
1791			10/23/2022								
1792			10/24/2022								
1793			10/25/2022								
1794			10/26/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1795			10/27/2022								
1796			10/28/2022								
1797			10/29/2022								
1798			10/30/2022								
1799			10/31/2022								
1800			11/1/2022								
1801			11/2/2022								
1802			11/3/2022								
1803			11/4/2022								
1804			11/5/2022								
1805			11/6/2022								
1806			11/7/2022								
1807			11/8/2022								
1808			11/9/2022								
1809			11/10/2022								
1810			11/11/2022								
1811			11/12/2022								
1812			11/13/2022								
1813			11/14/2022								
1814			11/15/2022								
1815			11/16/2022								
1816			11/17/2022								
1817			11/18/2022								
1818			11/19/2022								
1819			11/20/2022								
1820			11/21/2022								
1821			11/22/2022								
1822			11/23/2022								
1823			11/24/2022								
1824			11/25/2022								
1825			11/26/2022								
1826			11/27/2022								
1827			11/28/2022								
1828			11/29/2022								
1829			11/30/2022								
1830			12/1/2022								
1831			12/2/2022								
1832			12/3/2022								
1833			12/4/2022								
1834			12/5/2022								
1835			12/6/2022								
1836			12/7/2022								
1837			12/8/2022								
1838			12/9/2022								
1839			12/10/2022								
1840			12/11/2022								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1841			12/12/2022								
1842			12/13/2022								
1843			12/14/2022								
1844			12/15/2022								
1845			12/16/2022								
1846			12/17/2022								
1847			12/18/2022								
1848			12/19/2022								
1849			12/20/2022								
1850			12/21/2022								
1851			12/22/2022								
1852			12/23/2022								
1853			12/24/2022								
1854			12/25/2022								
1855			12/26/2022								
1856			12/27/2022								
1857			12/28/2022								
1858			12/29/2022								
1859			12/30/2022								
1860			12/31/2022								
1861			1/1/2023								
1862			1/2/2023								
1863			1/3/2023								
1864			1/4/2023								
1865			1/5/2023								
1866			1/6/2023								
1867			1/7/2023								
1868			1/8/2023								
1869			1/9/2023								
1870			1/10/2023								
1871			1/11/2023								
1872			1/12/2023								
1873			1/13/2023								
1874			1/14/2023								
1875			1/15/2023								
1876			1/16/2023								
1877			1/17/2023								
1878			1/18/2023								
1879			1/19/2023								
1880			1/20/2023								
1881			1/21/2023								
1882			1/22/2023								
1883			1/23/2023								
1884			1/24/2023								
1885			1/25/2023								
1886			1/26/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1887			1/27/2023								
1888			1/28/2023								
1889			1/29/2023								
1890			1/30/2023								
1891			1/31/2023								
1892			2/1/2023								
1893			2/2/2023								
1894			2/3/2023								
1895			2/4/2023								
1896			2/5/2023								
1897			2/6/2023								
1898			2/7/2023								
1899			2/8/2023								
1900			2/9/2023								
1901			2/10/2023								
1902			2/11/2023								
1903			2/12/2023								
1904			2/13/2023								
1905			2/14/2023								
1906			2/15/2023								
1907			2/16/2023								
1908			2/17/2023								
1909			2/18/2023								
1910			2/19/2023								
1911			2/20/2023								
1912			2/21/2023								
1913			2/22/2023								
1914			2/23/2023								
1915			2/24/2023								
1916			2/25/2023								
1917			2/26/2023								
1918			2/27/2023								
1919			2/28/2023								
1920			3/1/2023								
1921			3/2/2023								
1922			3/3/2023								
1923			3/4/2023								
1924			3/5/2023								
1925			3/6/2023								
1926			3/7/2023								
1927			3/8/2023								
1928			3/9/2023								
1929			3/10/2023								
1930			3/11/2023								
1931			3/12/2023								
1932			3/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1933			3/14/2023								
1934			3/15/2023								
1935			3/16/2023								
1936			3/17/2023								
1937			3/18/2023								
1938			3/19/2023								
1939			3/20/2023								
1940			3/21/2023								
1941			3/22/2023								
1942			3/23/2023								
1943			3/24/2023								
1944			3/25/2023								
1945			3/26/2023								
1946			3/27/2023								
1947			3/28/2023								
1948			3/29/2023								
1949			3/30/2023								
1950			3/31/2023								
1951			4/1/2023								
1952			4/2/2023								
1953			4/3/2023								
1954			4/4/2023								
1955			4/5/2023								
1956			4/6/2023								
1957			4/7/2023								
1958			4/8/2023								
1959			4/9/2023								
1960			4/10/2023								
1961			4/11/2023								
1962			4/12/2023								
1963			4/13/2023								
1964			4/14/2023								
1965			4/15/2023								
1966			4/16/2023								
1967			4/17/2023								
1968			4/18/2023								
1969			4/19/2023								
1970			4/20/2023								
1971			4/21/2023								
1972			4/22/2023								
1973			4/23/2023								
1974			4/24/2023								
1975			4/25/2023								
1976			4/26/2023								
1977			4/27/2023								
1978			4/28/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
1979			4/29/2023								
1980			4/30/2023								
1981			5/1/2023								
1982			5/2/2023								
1983			5/3/2023								
1984			5/4/2023								
1985			5/5/2023								
1986			5/6/2023								
1987			5/7/2023								
1988			5/8/2023								
1989			5/9/2023								
1990			5/10/2023								
1991			5/11/2023								
1992			5/12/2023								
1993			5/13/2023								
1994			5/14/2023								
1995			5/15/2023								
1996			5/16/2023								
1997			5/17/2023								
1998			5/18/2023								
1999			5/19/2023								
2000			5/20/2023								
2001			5/21/2023								
2002			5/22/2023								
2003			5/23/2023								
2004			5/24/2023								
2005			5/25/2023								
2006			5/26/2023								
2007			5/27/2023								
2008			5/28/2023								
2009			5/29/2023								
2010			5/30/2023								
2011			5/31/2023								
2012			6/1/2023								
2013			6/2/2023								
2014			6/3/2023								
2015			6/4/2023								
2016			6/5/2023								
2017			6/6/2023								
2018			6/7/2023								
2019			6/8/2023								
2020			6/9/2023								
2021			6/10/2023								
2022			6/11/2023								
2023			6/12/2023								
2024			6/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2025			6/14/2023								
2026			6/15/2023								
2027			6/16/2023								
2028			6/17/2023								
2029			6/18/2023								
2030			6/19/2023								
2031			6/20/2023								
2032			6/21/2023								
2033			6/22/2023								
2034			6/23/2023								
2035			6/24/2023								
2036			6/25/2023								
2037			6/26/2023								
2038			6/27/2023								
2039			6/28/2023								
2040			6/29/2023								
2041			6/30/2023								
2042			7/1/2023								
2043			7/2/2023								
2044			7/3/2023								
2045			7/4/2023								
2046			7/5/2023								
2047			7/6/2023								
2048			7/7/2023								
2049			7/8/2023								
2050			7/9/2023								
2051			7/10/2023								
2052			7/11/2023								
2053			7/12/2023								
2054			7/13/2023								
2055			7/14/2023								
2056			7/15/2023								
2057			7/16/2023								
2058			7/17/2023								
2059			7/18/2023								
2060			7/19/2023								
2061			7/20/2023								
2062			7/21/2023								
2063			7/22/2023								
2064			7/23/2023								
2065			7/24/2023								
2066			7/25/2023								
2067			7/26/2023								
2068			7/27/2023								
2069			7/28/2023								
2070			7/29/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2071			7/30/2023								
2072			7/31/2023								
2073			8/1/2023								
2074			8/2/2023								
2075			8/3/2023								
2076			8/4/2023								
2077			8/5/2023								
2078			8/6/2023								
2079			8/7/2023								
2080			8/8/2023								
2081			8/9/2023								
2082			8/10/2023								
2083			8/11/2023								
2084			8/12/2023								
2085			8/13/2023								
2086			8/14/2023								
2087			8/15/2023								
2088			8/16/2023								
2089			8/17/2023								
2090			8/18/2023								
2091			8/19/2023								
2092			8/20/2023								
2093			8/21/2023								
2094			8/22/2023								
2095			8/23/2023								
2096			8/24/2023								
2097			8/25/2023								
2098			8/26/2023								
2099			8/27/2023								
2100			8/28/2023								
2101			8/29/2023								
2102			8/30/2023								
2103			8/31/2023								
2104			9/1/2023								
2105			9/2/2023								
2106			9/3/2023								
2107			9/4/2023								
2108			9/5/2023								
2109			9/6/2023								
2110			9/7/2023								
2111			9/8/2023								
2112			9/9/2023								
2113			9/10/2023								
2114			9/11/2023								
2115			9/12/2023								
2116			9/13/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2117			9/14/2023								
2118			9/15/2023								
2119			9/16/2023								
2120			9/17/2023								
2121			9/18/2023								
2122			9/19/2023								
2123			9/20/2023								
2124			9/21/2023								
2125			9/22/2023								
2126			9/23/2023								
2127			9/24/2023								
2128			9/25/2023								
2129			9/26/2023								
2130			9/27/2023								
2131			9/28/2023								
2132			9/29/2023								
2133			9/30/2023								
2134			10/1/2023								
2135			10/2/2023								
2136			10/3/2023								
2137			10/4/2023								
2138			10/5/2023								
2139			10/6/2023								
2140			10/7/2023								
2141			10/8/2023								
2142			10/9/2023								
2143			10/10/2023								
2144			10/11/2023								
2145			10/12/2023								
2146			10/13/2023								
2147			10/14/2023								
2148			10/15/2023								
2149			10/16/2023								
2150			10/17/2023								
2151			10/18/2023								
2152			10/19/2023								
2153			10/20/2023								
2154			10/21/2023								
2155			10/22/2023								
2156			10/23/2023								
2157			10/24/2023								
2158			10/25/2023								
2159			10/26/2023								
2160			10/27/2023								
2161			10/28/2023								
2162			10/29/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2163			10/30/2023								
2164			10/31/2023								
2165			11/1/2023								
2166			11/2/2023								
2167			11/3/2023								
2168			11/4/2023								
2169			11/5/2023								
2170			11/6/2023								
2171			11/7/2023								
2172			11/8/2023								
2173			11/9/2023								
2174			11/10/2023								
2175			11/11/2023								
2176			11/12/2023								
2177			11/13/2023								
2178			11/14/2023								
2179			11/15/2023								
2180			11/16/2023								
2181			11/17/2023								
2182			11/18/2023								
2183			11/19/2023								
2184			11/20/2023								
2185			11/21/2023								
2186			11/22/2023								
2187			11/23/2023								
2188			11/24/2023								
2189			11/25/2023								
2190			11/26/2023								
2191			11/27/2023								
2192			11/28/2023								
2193			11/29/2023								
2194			11/30/2023								
2195			12/1/2023								
2196			12/2/2023								
2197			12/3/2023								
2198			12/4/2023								
2199			12/5/2023								
2200			12/6/2023								
2201			12/7/2023								
2202			12/8/2023								
2203			12/9/2023								
2204			12/10/2023								
2205			12/11/2023								
2206			12/12/2023								
2207			12/13/2023								
2208			12/14/2023								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2209			12/15/2023								
2210			12/16/2023								
2211			12/17/2023								
2212			12/18/2023								
2213			12/19/2023								
2214			12/20/2023								
2215			12/21/2023								
2216			12/22/2023								
2217			12/23/2023								
2218			12/24/2023								
2219			12/25/2023								
2220			12/26/2023								
2221			12/27/2023								
2222			12/28/2023								
2223			12/29/2023								
2224			12/30/2023								
2225			12/31/2023								
2226			1/1/2024								
2227			1/2/2024								
2228			1/3/2024								
2229			1/4/2024								
2230			1/5/2024								
2231			1/6/2024								
2232			1/7/2024								
2233			1/8/2024								
2234			1/9/2024								
2235			1/10/2024								
2236			1/11/2024								
2237			1/12/2024								
2238			1/13/2024								
2239			1/14/2024								
2240			1/15/2024								
2241			1/16/2024								
2242			1/17/2024								
2243			1/18/2024								
2244			1/19/2024								
2245			1/20/2024								
2246			1/21/2024								
2247			1/22/2024								
2248			1/23/2024								
2249			1/24/2024								
2250			1/25/2024								
2251			1/26/2024								
2252			1/27/2024								
2253			1/28/2024								
2254			1/29/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2255			1/30/2024								
2256			1/31/2024								
2257			2/1/2024								
2258			2/2/2024								
2259			2/3/2024								
2260			2/4/2024								
2261			2/5/2024								
2262			2/6/2024								
2263			2/7/2024								
2264			2/8/2024								
2265			2/9/2024								
2266			2/10/2024								
2267			2/11/2024								
2268			2/12/2024								
2269			2/13/2024								
2270			2/14/2024								
2271			2/15/2024								
2272			2/16/2024								
2273			2/17/2024								
2274			2/18/2024								
2275			2/19/2024								
2276			2/20/2024								
2277			2/21/2024								
2278			2/22/2024								
2279			2/23/2024								
2280			2/24/2024								
2281			2/25/2024								
2282			2/26/2024								
2283			2/27/2024								
2284			2/28/2024								
2285			2/29/2024								
2286			3/1/2024								
2287			3/2/2024								
2288			3/3/2024								
2289			3/4/2024								
2290			3/5/2024								
2291			3/6/2024								
2292			3/7/2024								
2293			3/8/2024								
2294			3/9/2024								
2295			3/10/2024								
2296			3/11/2024								
2297			3/12/2024								
2298			3/13/2024								
2299			3/14/2024								
2300			3/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2301			3/16/2024								
2302			3/17/2024								
2303			3/18/2024								
2304			3/19/2024								
2305			3/20/2024								
2306			3/21/2024								
2307			3/22/2024								
2308			3/23/2024								
2309			3/24/2024								
2310			3/25/2024								
2311			3/26/2024								
2312			3/27/2024								
2313			3/28/2024								
2314			3/29/2024								
2315			3/30/2024								
2316			3/31/2024								
2317			4/1/2024								
2318			4/2/2024								
2319			4/3/2024								
2320			4/4/2024								
2321			4/5/2024								
2322			4/6/2024								
2323			4/7/2024								
2324			4/8/2024								
2325			4/9/2024								
2326			4/10/2024								
2327			4/11/2024								
2328			4/12/2024								
2329			4/13/2024								
2330			4/14/2024								
2331			4/15/2024								
2332			4/16/2024								
2333			4/17/2024								
2334			4/18/2024								
2335			4/19/2024								
2336			4/20/2024								
2337			4/21/2024								
2338			4/22/2024								
2339			4/23/2024								
2340			4/24/2024								
2341			4/25/2024								
2342			4/26/2024								
2343			4/27/2024								
2344			4/28/2024								
2345			4/29/2024								
2346			4/30/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2347			5/1/2024								
2348			5/2/2024								
2349			5/3/2024								
2350			5/4/2024								
2351			5/5/2024								
2352			5/6/2024								
2353			5/7/2024								
2354			5/8/2024								
2355			5/9/2024								
2356			5/10/2024								
2357			5/11/2024								
2358			5/12/2024								
2359			5/13/2024								
2360			5/14/2024								
2361			5/15/2024								
2362			5/16/2024								
2363			5/17/2024								
2364			5/18/2024								
2365			5/19/2024								
2366			5/20/2024								
2367			5/21/2024								
2368			5/22/2024								
2369			5/23/2024								
2370			5/24/2024								
2371			5/25/2024								
2372			5/26/2024								
2373			5/27/2024								
2374			5/28/2024								
2375			5/29/2024								
2376			5/30/2024								
2377			5/31/2024								
2378			6/1/2024								
2379			6/2/2024								
2380			6/3/2024								
2381			6/4/2024								
2382			6/5/2024								
2383			6/6/2024								
2384			6/7/2024								
2385			6/8/2024								
2386			6/9/2024								
2387			6/10/2024								
2388			6/11/2024								
2389			6/12/2024								
2390			6/13/2024								
2391			6/14/2024								
2392			6/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2393			6/16/2024								
2394			6/17/2024								
2395			6/18/2024								
2396			6/19/2024								
2397			6/20/2024								
2398			6/21/2024								
2399			6/22/2024								
2400			6/23/2024								
2401			6/24/2024								
2402			6/25/2024								
2403			6/26/2024								
2404			6/27/2024								
2405			6/28/2024								
2406			6/29/2024								
2407			6/30/2024								
2408			7/1/2024								
2409			7/2/2024								
2410			7/3/2024								
2411			7/4/2024								
2412			7/5/2024								
2413			7/6/2024								
2414			7/7/2024								
2415			7/8/2024								
2416			7/9/2024								
2417			7/10/2024								
2418			7/11/2024								
2419			7/12/2024								
2420			7/13/2024								
2421			7/14/2024								
2422			7/15/2024								
2423			7/16/2024								
2424			7/17/2024								
2425			7/18/2024								
2426			7/19/2024								
2427			7/20/2024								
2428			7/21/2024								
2429			7/22/2024								
2430			7/23/2024								
2431			7/24/2024								
2432			7/25/2024								
2433			7/26/2024								
2434			7/27/2024								
2435			7/28/2024								
2436			7/29/2024								
2437			7/30/2024								
2438			7/31/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2439			8/1/2024								
2440			8/2/2024								
2441			8/3/2024								
2442			8/4/2024								
2443			8/5/2024								
2444			8/6/2024								
2445			8/7/2024								
2446			8/8/2024								
2447			8/9/2024								
2448			8/10/2024								
2449			8/11/2024								
2450			8/12/2024								
2451			8/13/2024								
2452			8/14/2024								
2453			8/15/2024								
2454			8/16/2024								
2455			8/17/2024								
2456			8/18/2024								
2457			8/19/2024								
2458			8/20/2024								
2459			8/21/2024								
2460			8/22/2024								
2461			8/23/2024								
2462			8/24/2024								
2463			8/25/2024								
2464			8/26/2024								
2465			8/27/2024								
2466			8/28/2024								
2467			8/29/2024								
2468			8/30/2024								
2469			8/31/2024								
2470			9/1/2024								
2471			9/2/2024								
2472			9/3/2024								
2473			9/4/2024								
2474			9/5/2024								
2475			9/6/2024								
2476			9/7/2024								
2477			9/8/2024								
2478			9/9/2024								
2479			9/10/2024								
2480			9/11/2024								
2481			9/12/2024								
2482			9/13/2024								
2483			9/14/2024								
2484			9/15/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2485			9/16/2024								
2486			9/17/2024								
2487			9/18/2024								
2488			9/19/2024								
2489			9/20/2024								
2490			9/21/2024								
2491			9/22/2024								
2492			9/23/2024								
2493			9/24/2024								
2494			9/25/2024								
2495			9/26/2024								
2496			9/27/2024								
2497			9/28/2024								
2498			9/29/2024								
2499			9/30/2024								
2500			10/1/2024								
2501			10/2/2024								
2502			10/3/2024								
2503			10/4/2024								
2504			10/5/2024								
2505			10/6/2024								
2506			10/7/2024								
2507			10/8/2024								
2508			10/9/2024								
2509			10/10/2024								
2510			10/11/2024								
2511			10/12/2024								
2512			10/13/2024								
2513			10/14/2024								
2514			10/15/2024								
2515			10/16/2024								
2516			10/17/2024								
2517			10/18/2024								
2518			10/19/2024								
2519			10/20/2024								
2520			10/21/2024								
2521			10/22/2024								
2522			10/23/2024								
2523			10/24/2024								
2524			10/25/2024								
2525			10/26/2024								
2526			10/27/2024								
2527			10/28/2024								
2528			10/29/2024								
2529			10/30/2024								
2530			10/31/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2531			11/1/2024								
2532			11/2/2024								
2533			11/3/2024								
2534			11/4/2024								
2535			11/5/2024								
2536			11/6/2024								
2537			11/7/2024								
2538			11/8/2024								
2539			11/9/2024								
2540			11/10/2024								
2541			11/11/2024								
2542			11/12/2024								
2543			11/13/2024								
2544			11/14/2024								
2545			11/15/2024								
2546			11/16/2024								
2547			11/17/2024								
2548			11/18/2024								
2549			11/19/2024								
2550			11/20/2024								
2551			11/21/2024								
2552			11/22/2024								
2553			11/23/2024								
2554			11/24/2024								
2555			11/25/2024								
2556			11/26/2024								
2557			11/27/2024								
2558			11/28/2024								
2559			11/29/2024								
2560			11/30/2024								
2561			12/1/2024								
2562			12/2/2024								
2563			12/3/2024								
2564			12/4/2024								
2565			12/5/2024								
2566			12/6/2024								
2567			12/7/2024								
2568			12/8/2024								
2569			12/9/2024								
2570			12/10/2024								
2571			12/11/2024								
2572			12/12/2024								
2573			12/13/2024								
2574			12/14/2024								
2575			12/15/2024								
2576			12/16/2024								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2577			12/17/2024								
2578			12/18/2024								
2579			12/19/2024								
2580			12/20/2024								
2581			12/21/2024								
2582			12/22/2024								
2583			12/23/2024								
2584			12/24/2024								
2585			12/25/2024								
2586			12/26/2024								
2587			12/27/2024								
2588			12/28/2024								
2589			12/29/2024								
2590			12/30/2024								
2591			12/31/2024								
2592			1/1/2025								
2593			1/2/2025								
2594			1/3/2025								
2595			1/4/2025								
2596			1/5/2025								
2597			1/6/2025								
2598			1/7/2025								
2599			1/8/2025								
2600			1/9/2025								
2601			1/10/2025								
2602			1/11/2025								
2603			1/12/2025								
2604			1/13/2025								
2605			1/14/2025								
2606			1/15/2025								
2607			1/16/2025								
2608			1/17/2025								
2609			1/18/2025								
2610			1/19/2025								
2611			1/20/2025								
2612			1/21/2025								
2613			1/22/2025								
2614			1/23/2025								
2615			1/24/2025								
2616			1/25/2025								
2617			1/26/2025								
2618			1/27/2025								
2619			1/28/2025								
2620			1/29/2025								
2621			1/30/2025								
2622			1/31/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2623			2/1/2025								
2624			2/2/2025								
2625			2/3/2025								
2626			2/4/2025								
2627			2/5/2025								
2628			2/6/2025								
2629			2/7/2025								
2630			2/8/2025								
2631			2/9/2025								
2632			2/10/2025								
2633			2/11/2025								
2634			2/12/2025								
2635			2/13/2025								
2636			2/14/2025								
2637			2/15/2025								
2638			2/16/2025								
2639			2/17/2025								
2640			2/18/2025								
2641			2/19/2025								
2642			2/20/2025								
2643			2/21/2025								
2644			2/22/2025								
2645			2/23/2025								
2646			2/24/2025								
2647			2/25/2025								
2648			2/26/2025								
2649			2/27/2025								
2650			2/28/2025								
2651			3/1/2025								
2652			3/2/2025								
2653			3/3/2025								
2654			3/4/2025								
2655			3/5/2025								
2656			3/6/2025								
2657			3/7/2025								
2658			3/8/2025								
2659			3/9/2025								
2660			3/10/2025								
2661			3/11/2025								
2662			3/12/2025								
2663			3/13/2025								
2664			3/14/2025								
2665			3/15/2025								
2666			3/16/2025								
2667			3/17/2025								
2668			3/18/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2669			3/19/2025								
2670			3/20/2025								
2671			3/21/2025								
2672			3/22/2025								
2673			3/23/2025								
2674			3/24/2025								
2675			3/25/2025								
2676			3/26/2025								
2677			3/27/2025								
2678			3/28/2025								
2679			3/29/2025								
2680			3/30/2025								
2681			3/31/2025								
2682			4/1/2025								
2683			4/2/2025								
2684			4/3/2025								
2685			4/4/2025								
2686			4/5/2025								
2687			4/6/2025								
2688			4/7/2025								
2689			4/8/2025								
2690			4/9/2025								
2691			4/10/2025								
2692			4/11/2025								
2693			4/12/2025								
2694			4/13/2025								
2695			4/14/2025								
2696			4/15/2025								
2697			4/16/2025								
2698			4/17/2025								
2699			4/18/2025								
2700			4/19/2025								
2701			4/20/2025								
2702			4/21/2025								
2703			4/22/2025								
2704			4/23/2025								
2705			4/24/2025								
2706			4/25/2025								
2707			4/26/2025								
2708			4/27/2025								
2709			4/28/2025								
2710			4/29/2025								
2711			4/30/2025								
2712			5/1/2025								
2713			5/2/2025								
2714			5/3/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2715			5/4/2025								
2716			5/5/2025								
2717			5/6/2025								
2718			5/7/2025								
2719			5/8/2025								
2720			5/9/2025								
2721			5/10/2025								
2722			5/11/2025								
2723			5/12/2025								
2724			5/13/2025								
2725			5/14/2025								
2726			5/15/2025								
2727			5/16/2025								
2728			5/17/2025								
2729			5/18/2025								
2730			5/19/2025								
2731			5/20/2025								
2732			5/21/2025								
2733			5/22/2025								
2734			5/23/2025								
2735			5/24/2025								
2736			5/25/2025								
2737			5/26/2025								
2738			5/27/2025								
2739			5/28/2025								
2740			5/29/2025								
2741			5/30/2025								
2742			5/31/2025								
2743			6/1/2025								
2744			6/2/2025								
2745			6/3/2025								
2746			6/4/2025								
2747			6/5/2025								
2748			6/6/2025								
2749			6/7/2025								
2750			6/8/2025								
2751			6/9/2025								
2752			6/10/2025								
2753			6/11/2025								
2754			6/12/2025								
2755			6/13/2025								
2756			6/14/2025								
2757			6/15/2025								
2758			6/16/2025								
2759			6/17/2025								
2760			6/18/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2761			6/19/2025								
2762			6/20/2025								
2763			6/21/2025								
2764			6/22/2025								
2765			6/23/2025								
2766			6/24/2025								
2767			6/25/2025								
2768			6/26/2025								
2769			6/27/2025								
2770			6/28/2025								
2771			6/29/2025								
2772			6/30/2025								
2773			7/1/2025								
2774			7/2/2025								
2775			7/3/2025								
2776			7/4/2025								
2777			7/5/2025								
2778			7/6/2025								
2779			7/7/2025								
2780			7/8/2025								
2781			7/9/2025								
2782			7/10/2025								
2783			7/11/2025								
2784			7/12/2025								
2785			7/13/2025								
2786			7/14/2025								
2787			7/15/2025								
2788			7/16/2025								
2789			7/17/2025								
2790			7/18/2025								
2791			7/19/2025								
2792			7/20/2025								
2793			7/21/2025								
2794			7/22/2025								
2795			7/23/2025								
2796			7/24/2025								
2797			7/25/2025								
2798			7/26/2025								
2799			7/27/2025								
2800			7/28/2025								
2801			7/29/2025								
2802			7/30/2025								
2803			7/31/2025								
2804			8/1/2025								
2805			8/2/2025								
2806			8/3/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2807			8/4/2025								
2808			8/5/2025								
2809			8/6/2025								
2810			8/7/2025								
2811			8/8/2025								
2812			8/9/2025								
2813			8/10/2025								
2814			8/11/2025								
2815			8/12/2025								
2816			8/13/2025								
2817			8/14/2025								
2818			8/15/2025								
2819			8/16/2025								
2820			8/17/2025								
2821			8/18/2025								
2822			8/19/2025								
2823			8/20/2025								
2824			8/21/2025								
2825			8/22/2025								
2826			8/23/2025								
2827			8/24/2025								
2828			8/25/2025								
2829			8/26/2025								
2830			8/27/2025								
2831			8/28/2025								
2832			8/29/2025								
2833			8/30/2025								
2834			8/31/2025								
2835			9/1/2025								
2836			9/2/2025								
2837			9/3/2025								
2838			9/4/2025								
2839			9/5/2025								
2840			9/6/2025								
2841			9/7/2025								
2842			9/8/2025								
2843			9/9/2025								
2844			9/10/2025								
2845			9/11/2025								
2846			9/12/2025								
2847			9/13/2025								
2848			9/14/2025								
2849			9/15/2025								
2850			9/16/2025								
2851			9/17/2025								
2852			9/18/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2853			9/19/2025								
2854			9/20/2025								
2855			9/21/2025								
2856			9/22/2025								
2857			9/23/2025								
2858			9/24/2025								
2859			9/25/2025								
2860			9/26/2025								
2861			9/27/2025								
2862			9/28/2025								
2863			9/29/2025								
2864			9/30/2025								
2865			10/1/2025								
2866			10/2/2025								
2867			10/3/2025								
2868			10/4/2025								
2869			10/5/2025								
2870			10/6/2025								
2871			10/7/2025								
2872			10/8/2025								
2873			10/9/2025								
2874			10/10/2025								
2875			10/11/2025								
2876			10/12/2025								
2877			10/13/2025								
2878			10/14/2025								
2879			10/15/2025								
2880			10/16/2025								
2881			10/17/2025								
2882			10/18/2025								
2883			10/19/2025								
2884			10/20/2025								
2885			10/21/2025								
2886			10/22/2025								
2887			10/23/2025								
2888			10/24/2025								
2889			10/25/2025								
2890			10/26/2025								
2891			10/27/2025								
2892			10/28/2025								
2893			10/29/2025								
2894			10/30/2025								
2895			10/31/2025								
2896			11/1/2025								
2897			11/2/2025								
2898			11/3/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2899			11/4/2025								
2900			11/5/2025								
2901			11/6/2025								
2902			11/7/2025								
2903			11/8/2025								
2904			11/9/2025								
2905			11/10/2025								
2906			11/11/2025								
2907			11/12/2025								
2908			11/13/2025								
2909			11/14/2025								
2910			11/15/2025								
2911			11/16/2025								
2912			11/17/2025								
2913			11/18/2025								
2914			11/19/2025								
2915			11/20/2025								
2916			11/21/2025								
2917			11/22/2025								
2918			11/23/2025								
2919			11/24/2025								
2920			11/25/2025								
2921			11/26/2025								
2922			11/27/2025								
2923			11/28/2025								
2924			11/29/2025								
2925			11/30/2025								
2926			12/1/2025								
2927			12/2/2025								
2928			12/3/2025								
2929			12/4/2025								
2930			12/5/2025								
2931			12/6/2025								
2932			12/7/2025								
2933			12/8/2025								
2934			12/9/2025								
2935			12/10/2025								
2936			12/11/2025								
2937			12/12/2025								
2938			12/13/2025								
2939			12/14/2025								
2940			12/15/2025								
2941			12/16/2025								
2942			12/17/2025								
2943			12/18/2025								
2944			12/19/2025								

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J	K
2945			12/20/2025								
2946			12/21/2025								
2947			12/22/2025								
2948			12/23/2025								
2949			12/24/2025								
2950			12/25/2025								
2951			12/26/2025								
2952			12/27/2025								
2953			12/28/2025								
2954			12/29/2025								
2955			12/30/2025								
2956			12/31/2025								

AMERICAN OVERSIGHT